North Carolina

UNIFORM APPLICATION
FY 2007 - STATE IMPLEMENTATION REPORT

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 08/20/2007 - Expires 08/31/2008

(generated on 12-3-2007 4.13.59 PM)

Center for Mental Health Services
Division of State and Community Systems Development

Introduction:

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.

Table of Contents

State:
North Carolina

North Carolina

Adult - Summary of Areas Previously Identified by State as Needing Improvement

Adult - Report Summary of areas which the State identified in the prior FY's approved Plan as needing improvement

Adult – Summary of Areas Previously Identified by State as Needing Attention

Topics of Attention

During the State Fiscal Year 06-07, there have been positive changes which have come about or are continuing from areas of need identified earlier:

- On-going construction continues on the new regional psychiatric hospital in Butner, NC; this 432 bed facility will serve persons needing inpatient psychiatric services in both the north and south central regions of the state and is expected to open in January of 2008 and will replace two existing hospitals: John Umstead Hospital and Dorothea Dix Hospital.
- In 2006, the North Carolina General Assembly specified changes to the implementation of reform of the mental health, developmental disabilities, and substance abuse services system in House Bill 2077, Session Law 2006-142. These changes include having a clear and concise plan for service provision and the prudent use of local and state resources. The Division has identified specific goals for the next three years, including benchmarks of progress toward the goals. This document is known as the ***State Strategic Plan for 2007-2010***. Input into development of the Plan was solicited from Division staff, consumers, family members, and other stakeholders. A draft of the Plan was posted on the Division website for a 30-day public comment period in late spring of 2007; the final Plan now appears on the Division website.
- In state fiscal years 2006 and 2007, the Division continued the ongoing process of:
  --identifying gaps in services at the local level-including transition to best and promising service practices as well as improving penetration rates and continuity in service provision;
  -- quantifying the level of all resources (Medicaid, state funds, etc.) needed and available to close such service gaps; and
  --establishing an allocation system that would help ensure funding equity, i.e., equal access to services throughout the state, among Local Management Entities.
- The Division has created and implemented various committees, communications series, trainings and interactive events to improve communication with all participants and interested individuals: a) the External Advisory Team comprised of advocates, consumers, provider trade associations, the North Carolina Council of Community Programs, and other stakeholders to provide advice and guidance on policy decisions; b) the Provider Action Agenda Committee deals with the needs of providers in the new, privatized service delivery environment; c) hosted 16 Town Meetings across the state; d) created communication bulletins and implementation updates to inform the system; and e) created the Division's web site as a means to facilitate communication and reference for policy and events.

Other areas identified previously as needing attention include the need to develop supports for Evidence Based Practices.

Adult Mental Health Evidence-Based Practices
North Carolina is working to strengthen the development of Evidence-Based Practices in the state. With support from a federal Substance Abuse and Mental Health Services Administration/National Institute of Mental Health planning grant, North Carolina developed a plan: (1) to increase stakeholder interest and demand for effective evidence-based services; (2) to provide clinicians and clinical supervisors with the knowledge and skills necessary to deliver evidence-based services for adults with serious mental illness; and (3) to establish mechanisms at the state and local levels to support and maintain effective services. The NC Science to Service Project Consortium was formed and included a wide variety of advocates, providers, and researchers.

Also, through the generous support of a three year Duke Endowment Grant, the North Carolina Evidence-Based Practices Center was created and is located at Southern Regional AHEC. The North Carolina Evidence-Based Practices Center is the leader of intensive training in Evidence-Based Practices. These Evidence-Based Practices are key elements in the mental health reform process in North Carolina. The website address is as follows: www.NCEBPCENTER.ORG

The goal of the Evidence-Based Practice Center is to support reform efforts by introducing and disseminating evidence-based practices for the State Plan's target population of the adults and children with severe mental illness. Evidence based practices are treatment interventions for which there is consistent empirical support and are ready for wide dissemination. The North Carolina Evidence-Based Practice Center will assist in implementation of evidence-based practices using the evidence-based practices Toolkits. These Toolkits are standardized educational materials used to assist mental health providers in implementing evidence-based practices. Toolkit information can also be used to inform key stakeholder groups about evidence-based practices. The six toolkits on which the Evidence-Based Practice Center is conducting training around the State are: Assertive Community Treatment, Supported Employment, Family PsychoEducation, Integrated Dual Disorder Treatment, Medication Management, and Illness Management and Recovery.

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services received a grant to support a Mental Health Systems Transformation project in North Carolina in October, 2004. The goal of the Mental Health Systems Transformation Project is to assist four local management entities to develop the infrastructure necessary to support the implementation of evidence-based practices within their local communities. This Project, which ended in June, 2007, was a good fit within the overall science to service initiative mentioned above and further advanced the Division's efforts to consider how to develop the infrastructure and supports needed for evidence-based practices for consumers and their families. This Mental Health Systems Transformation Project brought together the North Carolina Division of Medical Assistance and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with community stakeholders, including consumers, the North Carolina Governor's Institute on Alcohol and Substance Abuse and national experts.

In 2005 the North Carolina Practice Improvement Collaborative (PIC) was formed to provide guidance in determining the future evidence based services and supports that will be provided through our public system. Division Director Mike Moseley appointed 60 people to serve as advisors to the Division. The advisory group is a partnership between consumers, clinicians and researchers. Science will inform the provision of services, and the experiences of consumers, family members, and service providers will guide research on future services and supports that might be provided.

Comprised of representatives of all three disabilities, the NC PIC meets quarterly to review and discuss relevant programs. Annually, the group presents a report of prioritized program recommendations to the Division Director at a public forum. This forum, defined as the North Carolina Practice Improvement Congress, will feature brief educational descriptions of the practices being recommended by the NC PIC in its report.

The Second Annual Practice Improvement Collaborative Congress was held in Raleigh, on May 14, 2007 and out of this meeting came the Practice Improvement Collaborative's recommendation that the Division adopt the following Evidence Based Practices and supports for consumers and their families: Supported Employment (Mental Health), START Model (Systematic, Therapeutic, Assessment, Respite and Treatment for those in crisis who are diagnosed with a Developmental Disability), MATRIX (Methamphetamine and other stimulant drug addiction), Seeking Safety (Substance Abuse and Trauma), and Strengthening the Family (Substance Abuse Prevention). The Evidence Based Practice model of Supported Employment is one in which employment specialists and mental health professionals work together with persons with severe mental illness to help them obtain and maintain competitive employment. Supported employment follows six principles: (1) Eligibility is based on consumer choice; (2) Employment is integrated with treatment; (3) Competitive employment is the goal; (4) Job search starts soon after a consumer expresses interest in working; (5) The follow-along supports are continuous; and (6) The consumer's preferences are important.

The mission for the NC PIC is to ensure that each time any North Carolinian—whether a child or an adult, a member of a majority or minority, from an urban or rural area—comes into contact with the DMHDDSAS system, that the individual will receive excellent care that is consistent with our scientific understanding of what works.

Rural and Housing/Homelessness Needs

Another area of need is service provision to rural and homeless populations. People in rural areas often live at some distance from service sites and lack of transportation is generally acknowledged as being a problem. To make services more accessible, providers may deliver services in rural counties using a variety of methods including satellite clinics, alternate clinic scheduling hours and days, rotation of clinical staff to off-site clinics, local coordinated transportation services, flexible appointment scheduling, co-location of services with other human service programs, and transportation by staff.

In terms of housing/homelessness, new resources have been developed in North Carolina. In fall 2005, the first rental assistance payments from the NC Dept of Health and Human Services and the NC Housing Finance Agency's Key Program were made. The Key Program provides an operating subsidy in the form of rental assistance for persons with disabilities in targeted Low-Income Housing Tax Credit units. The Key Program is jointly funded by the NCHFA' HOME Match funds and the Mental Health Trust Fund.

In July 2006, the North Carolina General Assembly created a new endeavor called the "Housing 400 Initiative" that builds on the partnership between the NC Dept. of Health and Human Services, the NC Division of MH/DD/SAS and the NC Housing Finance Agency. This Initiative is designed to increase the supply of "independent and supportive living apartments for persons with disabilities" that are affordable to persons with incomes at the level of Supplemental Security Income (SSI).

To make this goal a reality, $10,937,500 was allocated to the North Carolina Housing Finance Agency (NCHFA) for the development of rental housing and $1,205,000 was allocated to the North Carolina Department of Health and Human Services (DHHS) to provide rental assistance for the 400 units financed by NCHFA under the Initiative. The capital funds are available through two programs: The Housing 400 Initiative Supportive Housing Development Program (SHDP 400) and the Housing 400 Initiative Preservation Loan Program (PLP 400). In addition to the capital expenditures, the Housing 400 Initiative will fund up to 250 targeted units with Key Program assistance through the LIHTC development program. Currently as part of these housing initiatives, there are 495 units that will be developed and targeted to serve persons with disabilities and additional funding was appropriated by the 2007 session of the NC General Assembly to continue and expand both rental assistance and capital expenditures

North Carolina Mental Health Trust Fund to Increase Community Capacity
Another gap in the system is to reduce the number of readmissions to State Psychiatric Hospitals; one option for doing this is through building community capacity. The North Carolina General Assembly established a Mental Health Trust Fund in SFY 01-02. These funds have been used each year to provide one time start-up funding to increase community service capacity. For example, in SFY 06-07, the Division issued requests for applications from Local Management Entities in collaboration with contracted service providers to fund projects designed to assist with one-time non-recurring needs in SFY 06-07 and 07-08 related to the provision of community services to consumers. Initiatives that were funded included increasing local capacity to address the service needs of adults with mental illness, children with substance abuse, and adults with substance abuse.

State Mental Health Trust Funds were also used to fund a three year pilot project to address homelessness for people with disabilities by partnering staff devoted to the development of housing options with Assertive Community Treatment Teams and Community Support Teams. The combination of housing emphasis with treatment has been proven to be effective in other areas of the country.

The development of crisis service plans by the Local Management Entities (Area Authorities) is another venue for increasing community capacity and preventing or

reducing admission to psychiatric hospitals and will be discussed in more detail in another section.

North Carolina

Adult - Most Significant Events that Impacted the State Mental Health System in the Previous FY

Adult - Report Summary of the most significant events that impacted the mental health system of the State in the previous FY

Adult - Recent Significant Achievements:
Report Summary of the Most Significant Events that Impacted the Mental Health System of the State in the Previous Fiscal Year

Mental Health Reform
Six years ago North Carolina charted a course to reform the services it provides for people who experience mental illness, developmental disabilities and substance abuse. The journey began in 2001 when the North Carolina General Assembly set initial expectations for reform of the publicly funded system. The legislature mandated transformation of the way services were managed and delivered in the state. The required changes affect virtually every individual involved in the system – consumers and family members, management and staff of state operated facilities and community service providers, and State and local government. As a result, there have been and continue to be many ideas about the new system of services, as well as the natural resistance to such a major change.

There have been significant changes taking place in the public mental health, developmental disabilities, and substance abuse services system in the last several years. Following are some highlights regarding these changes taking place in State Fiscal Year 06-07 (please note: The North Carolina Mental Health Planning and Advisory Council members' input regarding challenges/needs, achievements, and priorities is detailed in this section pertaining to the significant events):

The ability to serve more people due to funding increases from the legislature in the 2006 session was a significant boost to transformation efforts. The State budget for FY 06-07 was approved with some very noteworthy funding increases: new general funds were approved, on a recurring basis, in the amount of $7,200,000 to be distributed to the Local Management Entities for mental health services and approval for $7,000,000 in recurring state service dollars to be used for crisis services, and $5,250,000 in non-recurring funding for start up costs to establish a continuum of regional/local crisis services.

As mentioned earlier, the Division has developed the ***State Strategic Plan for 2007-2010***. The Division has identified five specific goals to be reached within the next three years with specific benchmarks of progress toward these goals. They are as follows: (1) to establish and support a stable and high quality provider system with an appropriate number and choice of providers of desired services; (2) to continue development of comprehensive crisis services; (3) to achieve more integrated and standardized processes and procedures in the mental health/developmental disabilities/substance abuse services system; (4) to improve consumer outcomes related to housing; and (5) to improve consumer outcomes related to education and employment.

As the result of the **State Consumer and Family Advisory Committee** being codified in law (**S.L.2006-142 Section 5**) in 2006, the old State Consumer and Family Advisory Committee was disbanded and a new committee, appointed in accordance with the new law, began operations on November 9, 2006; the State Consumer and Family Advisory Committee is a self-governing and self-directed organization that advises the Dept. of

Health and Human Services and the General Assembly on the planning and management of the State's public mental health, developmental disabilities, and substance abuse services system and works directly with the Executive Leadership Team of the Division. Members to the State CFAC are appointed by: the President Pro Tem of the Senate, the Speaker of the House of Representatives, the North Carolina Council of Community Programs, the North Carolina Association of County Commissioners, and the Secretary of the Department of Health and Human Services.

In addition to the State Consumer and Family Advisory Committee, there are **local Consumer and Family Advisory Committees** in each Local Management Entity's catchment area that advise the Local Management Entity on the planning and management of the local public mental health/developmental disability/substance abuse service system.

On a related note, in terms of advocacy, the Division's **Advocacy and Customer Service** section is instrumental in the Department's commitment to customer service by training Division staff; responding to customer inquiries, complaints, requests for information and Medicaid recipients' appeals regarding services; and providing technical assistance to Local Management Entities as they develop customer service offices. Local offices are responsible for promoting public information about services and rights, supporting local Consumer and Family Advisory Committees and human rights committees and conducting rights investigations. The Division's Advocacy and Customer Service section also provides advocacy services to consumers who receive care and treatment in state operated facilities. Advocacy includes training of consumers, family members and facility staff and conducting rights investigations.

Another milestone in helping adults with serious mental illness in North Carolina is the recent passage of the mental health **Parity legislation** by the Senate and House; this bill requires health insurers in the state to provide the same level of coverage for treatment of severe depression, schizophrenia or other mental illnesses as they do for physical illnesses.

One recent significant achievement that reflects progress toward the development of a comprehensive community-based mental health system of care is the development of **crisis response plans** in each Local Management Entity around our State. A comprehensive crisis service system is critical to stabilize the system across all disabilities state-wide. Such a comprehensive system must be prepared to meet the needs of any individual who experiences a crisis related to a mental health or substance abuse problem or a developmental disability and be prepared to provide appropriate services that are evidence-based or best practices. At the community level, a comprehensive crisis service system must be totally integrated with the existing community medical and public safety emergency response system.

While state facilities clearly have an important role in a comprehensive crisis service system, admission to a state psychiatric hospital should be the choice of last resort. All too often, individuals who experience such a crisis are quickly transported by police to

hospital emergency rooms or to state operated psychiatric hospitals. Improved access to commitment evaluations and community resources serving as alternatives to state hospital admission are important in providing a comprehensive crisis system and in decreasing inappropriate state hospital admissions. Use of the state psychiatric hospitals or the alcohol and drug abuse treatment centers is quite appropriate when community options are exhausted and a thorough crisis evaluation has ruled out all less restrictive community alternatives.

When existing consumers of the system have a fully developed person-centered plan, including a crisis prevention/intervention plan and an assessment of health risk and safety, the consumers, family members and first responders know what actions are needed to promote health, independence and safety; to prevent escalation of the crisis; and to intervene in a way that is appropriate for the person. Crisis prevention begins with a good risk assessment and a plan that anticipates the supports needed for the person in the eventuality that a crisis occurs. Often, the crisis can be resolved in a timely manner in the person's home community given a comprehensive array of crisis services. Training of first responders regarding crisis planning and management is also critical. As mandated by the North Carolina General Assembly, each Local Management Entity's crisis plan must provide community crisis services for any person experiencing crisis due to a mental health or substance abuse problem or developmental disability. Further, the General Assembly appropriated funding for development of these services and for their ongoing operation. The Division contracted with consultants from Technical Assistance Collaborative, Inc. to assist with review of plans and provision of technical assistance to Local Management Entities in their implementation of crisis services through June 2008.

Another identified need is the **involvement of consumers in the planning and management of system services**; in three of the new service definitions approved in 2006 was the inclusion of a peer support specialist: Assertive Community Treatment Teams (must have at least one Certified Peer Support Specialist), Community Support Teams and Social Setting Detoxification (may utilize Certified Peer Support Specialists in service delivery). In addition to consumer involvement in the local Consumer and Family Advisory Committees and the State Consumer and Family Advisory Committee addressed earlier, consumers are also involved in the External Advisory Committee, the North Carolina NC TOPPS (Treatment Outcomes and Program Performance System) Advisory Committee (more information is available about NC TOPPS below), the North Carolina Mental Health Planning and Advisory Council, the Program Management Database Workgroup, the Non-Medicaid Appeals Panels, the Cultural Competency Advisory Group, the Hospitals Admissions and Discharge Planning Group, the Executive Leadership Team, the Therapeutic Crisis Intervention Group, the Provider Performance Workgroup, the Local Business Plan Observer Participant Panel, the monitoring of Local Management Entity Service Providers, the review of the Division's Consumer Friendly Strategic Plan, and Core Indicators Interviews.

The process of **transitioning service delivery** from the local area mental health, developmental disabilities, and substance abuse services authorities to public and private providers continues; over 1400 providers statewide have been endorsed.

The **North Carolina Treatment Outcomes and Program Performance System (NC TOPPS)** is the tool by which the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services measures the outcome(s) and performance of consumers of behavioral health services. NC TOPPS captures key information on a consumer's current episode of treatment. NC TOPPS aids in evaluation of active treatment services and provides data for meeting federal performance and outcome measurement requirements. This tool was activated earlier for individuals with substance abuse issues and more recently has begun capturing data for adults with mental illness and children with serious emotional disturbance.

The State Strategic Plan for 2007-2010, as with this Block Grant Plan, provides the opportunity to better integrate into practice the goals and priorities of the Division and those of the Council. Work continues in an effort to define a set of shared outcomes and measures among all the federal and state funding sources that will increase the Division's ability to report indicators of success when achieved. Consistent with the Division's mission and guiding principles outlined below, also as described throughout this section, the use of block grant funds will continue to support statewide system transformation building on the significant achievements, goals and priorities as identified by the Division and the North Carolina Mental Health Planning & Advisory Council. Planning Council members recognize their role as constituents who are engaged in more than 60 different leadership roles and/or collaborative partnerships in their community, state, and national basis. Council members bring and exchange information at the Council table as well as among these numerous and diverse spheres of influence. This advocacy-related list is included in appendix B of this Report, as well as in the Child Section of the Report.

Division of MHDDSAS State Plan Mission
North Carolina will provide people with, or at risk of, mental illness, developmental disabilities and substance abuse problems and their families the necessary prevention, intervention, treatment services and supports they need to live successfully in communities of their choice.

Division of MHDDSAS State Plan Guiding Principles
- Participant driven
- Community based
- Prevention focused and recovery outcome oriented
- Reflect best treatment/support practices
- Cost effective

Division of MHDDSAS State Plan – The Vision for a Transformed System
- Public and social policy toward people with disabilities will be respectful, fair and recognize the need to assist all that need help.

- Services for persons with mental illness, developmental disabilities and substance abuse problems will be cost effective, will optimize available

resources – including natural and community supports – and will be adequately funded by private and public payers.

- System elements will be seamless: consumers, families, policymakers, advocates and qualified providers will unite in a common approach that emphasizes support, education/training, rehabilitation and recovery.

- All organizations and individuals that serve people with mental health, developmental disabilities and/or substance abuse problems will work together to enable consumers to live successfully in their communities.

Consumers will have:

- Meaningful input into the design and planning of the service system.
- Information about services, how to access them and how to voice complaints.
- Easy, immediate access to appropriate services.
- Educational, employment or vocational experiences that encourage individual growth, personal responsibility and enjoyment of life.
- Safe and humane living conditions in communities of their choice.
- Reduced involvement with the justice system.
- Services that prevent and resolve crises.
- Opportunities to participate in community life, to pursue relationship with others and to make choices that enhance their productivity, well being and quality of life.
- Satisfaction with the quality and quantity of services.
- Access to an orderly, fair and timely system of arbitration and resolution.

Planning Council Charge, Role, and Activities

North Carolina Mental Health Planning Council: Activities and Accomplishments

Mental health planning and advisory councils exist in every State and U.S. Territory because of the passage of federal law 99-660 in 1986, continuing through Public Law 101-639 and Public Law 102-321 in 1992. The federal law states that the planning council is expected to do the following:

1. To review the Mental Health Block Grant Plan and to make recommendations.
2. To serve as an advocate for adults with a serious mental illness, children with a serious emotional disturbance, and other individuals with mental illnesses.
3. To monitor, review and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

Individuals shall be appointed by the Secretary of the Department of Health and Human Services to fill membership positions for 3 year terms. The North Carolina Mental Health Planning Council is made up of 28 members, ten of whom represent adult consumers with mental illness or family members of children with serious emotional disturbance, eight of whom represent mental health advocacy organizations, eight of whom are state employees and two of whom are providers of mental health services. The Council meets six times per year in Raleigh, the capital of North

Carolina. Below is a listing of Planning Council events, activities, and accomplishments that have occurred within the past fiscal year.

July—September, 2006

- As a means to allow Planning Council members an opportunity to review information and data pertinent to their respective advocacy-orientation (for inclusion in the Block Grant Plan), there were separate committee meetings held in July; the Adult Committee met on July 14, 2006 and the Child/Family Committee met on July 21, 2006. Quality Management Team staff members were present at both committee meetings to inform Council members and respond to questions. For more details about the July Committee meetings, please follow this link to the Planning Council website: http://www.ncdhhs.gov/mhddsas/mhplanning/index.htm
- Division liaison staff discussed the Mental Health Block Grant Plan process and the timeline for the Plan and the Implementation Report (which assesses the progress made in the previous year's Plan).
- Council members reviewed the completed draft of the Plan and feedback was received. The review included a listing of Planning Council activities for the past year, as well as a review of the goals, objectives, updates, measures and data for indicators found in the Mental Health Block Grant Plan (that was due in 09/06 for FFY 07 and subsequent report due in 12/06 for FFY 06). Council discussion focused on setting priorities, and feedback regarding achievements and challenges of transformation to be included in this year's Plan. In the August, 2006 meeting, Council members voted on the priorities on which they wanted to focus during the upcoming meetings in FFY 2006-07.
- Council members requested the addition of Evidence-Based Practice Indicators in both the child and adult sections and this request was implemented via adding a data table in the adult section tracking consumers who receive Assertive Community Treatment (ACT) and by the addition of a data table in the child section which tracks children in Therapeutic Foster Care.
- A representative from Prevention and Early Intervention Team at the Division provided an update on the status of the System of Care (SOC) Coordinator positions; there will be one Coordinator per each of the 30 Local Management Entities or LMEs through the use of State recurring funds in order to expand SOC statewide.
- Chair asked the Council to review the draft transmittal letter that will accompany the Plan when it is submitted. Revisions were made at members' request and there was agreement that the letter would be sent as revised based on the discussion with the Chair's signature.

October—December, 2006

- Council members reviewed priorities they had chosen in the last meeting (August), with the framing of those five priorities into the agendas for the last three Council meetings in SFY 2006-07 (January, March, and May, 2007).
- To move these priorities from the "idea" stage to planned agenda items, Council members utilized the format for implementation planning from training done by staff from the National Association of Mental Health Planning and Advisory

Councils (NAMHPAC) in the spring of 2006, referred to as SMART Goals; SMART is an acronym which stands for S-Smart, M-Measurable, A-Agreed upon, R-Realistic, and T-Time-limited. This process involves identifying the SMART Goals, identifying any barriers or resources to achieving the goals, action steps to be taken, the person(s) responsible for working on the SMART Goals, and the timeframes for accomplishment. Council members identified questions for each of the meetings in which priorities would be discussed, such as resource information (what do we know, what do we need to know), resource contacts (who can share information about the particular area of priority--council member, staff member, outside speaker, etc.), and timeframes.

- Council members felt strongly that increasing service capacity, collaboration, and consumer and family involvement transcend all the other priorities and will be "embedded" within those ensuing presentations and Council discussions. Out of the October meeting came a table format document outlining the areas considered for each meeting dealing with priorities. As these January, March, and May meetings are held with discussion and information sharing, the resulting documentation of such will serve as resource information to inform Council dialogue and help shape recommendations regarding indicators or measures for the FFY 2007-08 MHBG Plan.
- Members reviewed and provided input and feedback for the Mental Health Block Grant Implementation Report (to be submitted 12/01/06) and considered the following as issues to be covered in future meetings: homeless population and how increasingly, veterans are falling into this group; transition services for children who age out of the child systems in DMH/DD/SAS, DSS (Division of Social Services), and DPI (Dept. of Public Instruction); linking crisis services with the reduction of consumer involvement in the justice system; and training (for consumers, family members, and providers); and the aging population with MI.
- A contract report was provided to members by the North Carolina Mental Health Consumers Organization (NCMHCO) Executive Director as they are one recipient of Mental Health Block Grant funding (NCMHCO activities: Wellness Recovery Action Plan (WRAP) Training in each region of the State, a statewide conference with awards banquet for 200 consumers with the theme of: *Discover Your Strengths—Achieve New Heights*.
- Council Chair was the Recipient of the 2007 North Carolina Mental Health Consumers Organization's Staff Award for Leadership, Advocacy, and Excellence and also serves as a SAMHSA (Substance Abuse and Mental Health Services Administration)/CMHS PAIMI (Center for Mental Health Services Protection and Advocacy for Individuals with Mental Illness) Peer Reviewer, NIMH (National Institute of Mental Health) Public Participant Reviewer and is a member of the Division's Practice Improvement Collaborative.
- October and November meetings focused on gathering input from Council members about achievements/accomplishments, and challenges/concerns both from the past year and priorities for the coming year (please refer to the Achievements, Challenges/Needs, and Priorities Section immediately following this quarterly list of Council highlights)
- The Housing Finance Agency Council representative indicated that there was new

Money available for supported housing; new apartment units have opened in Raleigh for persons with mental illness.

- The Division of Aging and Adult Services representative informed the Council that the Older Americans Act had been reauthorized; funds for grants will be appropriated to states for using Evidence-Based Practices in the treatment of older Americans.
- Members were able to have an open discussion with Division Director Mike Moseley during the November meeting with opportunities for frank questions and answers.
- Council members agreed and the motion was made and carried that the transmittal letter to accompany the Implementation Report when it is submitted will include recommendations/highlights as just discussed in the committees. The letter will go to the Executive Committee for final approval and then forwarding to Chair for signature.
- Members were given two handouts at the November meeting, one of which was the Council Meeting Schedule for 2007 and the other handout serves as a planning outline for SFY 2006-07 Council meetings and discussion of Block Grant criterion priorities as a basis for informing the Council. This outline covers the three remaining Council meetings in this fiscal year, with Block Grant Plan criteria indicated as well as Council priorities around each particular criterion.
- One Council member has been asked by her home county to serve on the committee which conducts the homeless count in January 2007; since homelessness is a priority of the Council, she will report back to the Council once this task has been completed.
- Linda Swann from NAMI (National Alliance on Mental Illness) delivered a contract report and discussed those contracts supported by Mental Health Block Grant funds, such as the Family to Family contract and the Young Families contract. Through Block Grant funds, she can also pay for consumers to help her present and she also utilizes the funds to help create and disseminate brochures to educate the community.

January—March, 2007

- In January, the meeting focused on Block Grant Criterion IV, Targeted Services to Homeless Populations. Council interests under this criterion include decreasing barriers to services, specifically in housing and transitions (e.g., as in transition from child to adult services or across systems). Panelists who informed the Council included Joan McAllister (Division of Social Services) who spoke about transition needs for children and youth, especially those who have been in foster care placements; Debra McHenry (Department of Public Instruction) spoke about the McKinney-Vento Homeless Education Act and discussed definitions and statistics related to that law. Debbie Webster (Division of Mental Health/Developmental Disabilities/Substance Abuse Services) spoke about the Projects for Assistance in Transition from Homelessness (PATH) programs in North Carolina; Glenn Silver, also from DMH/DD/SAS spoke about his role as Housing Coordinator for the Division and the housing initiatives and grants that he is involved with; and Mary Reca Todd from the North Carolina Housing Finance Agency spoke about the need

for supportive housing in our State and some of the recent housing achievements, in terms of funding and actual housing units.

- During January's meeting, the Vice-Chair began serving as Council Chair; nominations were taken for Vice-Chair and the new Vice-Chair was elected by the Council; the Child/Family Committee approved a new Committee Chair, along with a back-up.
- Shealy Thompson, Team Leader of the Quality Management Team, spoke to the Council about the recent change in summarizing the input from the North Carolina Consumer Satisfaction Survey. The major change in the survey methodology is what constitutes a positive response, based on how the consumer/family member responds to the survey questions. This change was the result of an effort to better align North Carolina's data information and implementation reporting process with federal and state protocols.
- In keeping with the Council priorities and their review of Block Grant Criterion V. (Management Systems: increase consumer and family involvement and workforce development), Ann Remington, Consumer Empowerment Team Leader, from the Advocacy and Customer Service Section presented on consumer and family member involvement with State and Local Consumer and Family Advisory Committees or CFACs.

  In terms of workforce development, information was shared with the Council regarding the Univ. of North Carolina at Chapel Hill School of Social Work's Behavioral Healthcare Resource Program (BHRP). The BHRP is designed to provide clinical consultation, technical assistance, and trainings designed for professionals working in the public mental health and substance abuse programs. Following are comments and considerations from Council members regarding workforce development:

  -look for ways to increase recovery based systems and principles in training
  -look for ways to inplement and train on the recovery model (consumer to consumer based training, not too clinical)
  -adjust qualifications of trainers (e.g., endorsed trainers have a Master's level education): increase number of trainings in which consumers/families are trainers, increase number of trainings and educational opportunities in which the design, writing, training, and evaluation are done by/with consumers/families as full partners
  -engage consumers/families in partners in cross-agency training as participants and trainers
  -establish peer specialist service definition for child and family Mental Health services/supports and use more broadly for adult services/supports (e.g., expanded definition for child and family could be used in schools and in coordinated school training; working example in place and being implemented in SFY07, also implementation of a blended child and family team curriculum (developed, tested, and trained by families of children with serious emotional disturbance), and blended funds from all child-serving agencies; establish good standards of practice and improve quality of services/supports provided
  -encourage Local Management Entities to use funds through non-UCR (Unit Cost

Reimbursement) to offer elective trainings developed and provided by consumers/ families as partners
-include Department of Corrections staff to help support treatment best practice and coordinate community re-entry
-update and maintain a training calendar to reach a broad audience

- A Council member participated in the homeless count in Greensboro
- Another Council member will be doing WRAP (Wellness Recovery Action Plan) Training in groups composed of ladies involved in the Work First Program, while another is doing WRAP training for children who reside in Level IV Group Homes.
- Another member has been working with the school system and juvenile justice system.
- One Council member discussed updates from the Division of Prisons and how they will be working with Division of Veteran Affairs on behalf of veterans before they are released from prison to initiate services.
- One Council member is now the Legislative Liaison for the NC Dept. of Juvenile Justice and Delinquency Prevention and will be able to do more advocacy.
- While in committee, members discussed training, education and advocacy-related efforts in which they are involved during the March meeting. This information will be used to update the document, *Consumer and Family Involvement and Advocacy Opportunities in North Carolina*, and further inform Council members about their fellow co-members' stakeholder activities.

April—June, 2007

- At the May meeting, the Council representative from the Division of Aging and Adult Services provided a report on the SAMHSA-sponsored workshop she attended entitled, *Making the Mental Health System Work for Older Adults with Mental Illness*.
- Presentations in the May meeting focused on MHBG Criterion II. Data Epidemiology and Criterion III. Children's Services. Antonio Coor from the Division's Justice Systems Innovations Team, presented on reducing mental health consumer involvement in the juvenile justice system via his overview of the MAJORS (Managing Access for Juvenile Offender Resources and Services) Program. Bob Kurtz, Ph.D., also from the Justice Systems Innovations Team, presented on reducing mental health consumer involvement in the Justice System (e.g., jail diversion), and brought Chris Wassmuth (Crisis Intervention Team Coordinator for Wake County) as his guest.
- Adult Committee members provided feedback during the May Committee meeting that will be submitted to the Quality Management Team regarding their review of specific questions in NC-TOPPS (Treatment Outcomes and Program Performance System) that relate to justice system involvement by the consumer.
- Council Chair discussed the approval by the Division to provide the Council with $1000 to spend during the next SFY (July 1, 2007- June 30, 2008). This is non-service money and the Division needs to have final approval of projects/plans before funds are actually expended. Options discussed today included conferences, trainings, having staff come down from the National Association of Mental Health Planning and Advisory Councils and do training, developing a questionnaire for

consumers/family members to respond to, or having focus groups around the state to get input and share Council information and educate people about the Council. The Chair will discuss this matter further with Bonnie Morell, Team Leader of the Best Practice Team in the Division, and then will update Council members.

- One Council member informed the Council about Coalition 2001's "Advocacy Rally Day" which will be held at the Legislative Building.
- Another member discussed the Medicaid Infrastructure Grant (MIG) that the Division of Vocational Rehabilitation holds, which has as one of its key elements, a Medicaid Buy-In component (people with disabilities could continue to work and "buy-in" to get their own Medicaid coverage). The request was made to the Council to write a letter supporting the application of a continuation grant if needed; Council members agreed by acclamation to write the letter via a drafting of such by the Executive Committee, if needed.
- Council members were asked to review the Division's new three year State Strategic Plan that is now posted on the Division website for public comment; the Council Chair asked members to send comments.
- Council Chair and Division staff attended the 2007 Joint National Conference on Mental Health Block Grant and National Conference on Mental Health Statistics.
- Members did hear proposals regarding possible recommendations from the Council to the Division of Mental Health/Developmental Disabilities/Substance Abuse Services about the use of the increased Block Grant funding received from the Substance Abuse and Mental Health Services Administration. Council Chair sent a letter to federal funders acknowledging Council's participation in this recommendation process.

Below is a list of comments, including the achievements, challenges, and priorities as provided by Council members in discussing transformation in general throughout the year, and in their review of the Community Mental Health Services Block Grant Plan.

North Carolina Mental Health Planning and Advisory Council Priority Areas of Focus during the FFY 07Plan year:

- Priority #1 – Criterion I. Community Based System: To increase service capacity.
- Priority #2 – Criterion IV. Rural and Homeless: To decrease barriers to services by increasing housing, transition supports for youth and young adults and for service coordination across systems.
- Priority #3 – Criterion V. Management Systems: To increase consumer & family involvement through implementing best practices, as trainers/co-trainers, and as informed consumers (informed consent, decision-making and choice).
- Priority #4 – V. Management Systems: To strengthen workforce development efforts in the implementation of training in evidenced based/promising practices, person centered planning and child and family teams a key component of System of Care.
- Priority #5 – Criterion II. Data Epidemiology and Criterion III. Children's Services: 1) To reduce MH consumer involvement in Justice System (e.g. jail diversion, etc); and 2) To reduce MH consumer involvement in juvenile justice system (e.g. courts, DJJDP, etc).

The Council has been mindful of and intends to continue to examine the data, trends, and make recommendations specific to the Block Grant and system as a whole. To guide this work, the Council will strive to frame their recommendations based on the responses to the following questions, "How do we define success? What does success look like?"

Achievements as Expressed by Planning Council Members:

- Training: Council members are involved in training, such as recovery training with Psychosocial Rehabilitation Programs, Wellness Recovery Action Plan (WRAP) training, Peer Support Specialist training, working with CFACs, and Family to Family training through NAMI (National Alliance on Mental Illness). In fact, NAMI's Family to Family training has expanded in number of attendees and in number of locations. LMEs are sending staff to trainings as well, such as WRAP training, Family to Family training and the Crisis Intervention Training (CIT). North Carolina Mental Health Consumer Organization has trained more WRAP facilitators and collaborates with other advocacy organizations in doing training. There have been 2 peer to peer specialists who have formed additional support groups; they had interest in going through the training and then went on to lead other support groups.
- Progress has been made in community capacity; if Community Support is done correctly, it does provide a unique support; Community Support Specialists have filled a gap in the service delivery system.
- Assertive Community Treatment Teams have been around a long time, but now we have an ACTT model with fidelity.
- Many Local Management Entities have provider meetings on a monthly basis.
- Peer Support Specialists can help consumers in the process of systems navigation and can link them with community resources.
- Despite North Carolina being a state in transition, there are growing "pockets of excellence" in specific locales.
- The Division of MH/DD/SAS and the legislature have put benchmarks in place to track Evidence-Based Practices and funding expenditures.
- The recent passage of the mental health Parity legislation by the Senate and House; this bill requires health insurers in the state to provide the same level of coverage for treatment of severe depression, schizophrenia or other mental illnesses as they do for physical illnesses.
- Local newspapers in many areas are now showing how the legislators voted; they are increasingly looking to consumers for input; articles are being written about local service providers to inform and educate the public.
- All Local Management Entities have crisis plans.
- Effective 2/07 the Interagency Memorandum of Agreement (IMOA) was signed and went into effect between the Division of Vocational Rehabilitation Services and the Division of Mental Health/Developmental Disabilities/Substance Abuse Services; this IMOA focuses on employment goals (some mutual goals between the two divisions and other individual divisional goals); some components include discharge planning from state psychiatric hospitals and training.

- One Council member has introduced WRAP training in adult day care settings in Wake County; she worked with older adults who had unmet needs and were dealing with loneliness and isolation.
- Council members voiced approval of the efforts going on around the State in terms of housing initiatives, such as the Housing 400 Initiative and support of the Key Program, which provides bridge funding or operating funds as a form of rental assistance. Committee members had specific areas of interest and focus in housing options: housing for those in recovery, housing for survivors of domestic violence (either permanent or transitional – beyond emergency shelters), CASA programs for women and children (with on-going education/training/support for substance abuse issues and parenting), and Oxford House programs for those in re-entry from the prison populations back into the community.
- Members support Division efforts to have Peer Support positions in the PATH (Programs for Assistance in Transition from Homelessness) programs.
- Achievements identified regarding transformation efforts included the following**:**
  -- Implementation of Evidenced Based Practices (EBP); possible measures that could be used to track the increase in EBPs include the number of children receiving EBP services, the number of providers endorsed to provide EBPs, such as Multi Systemic Therapy and Therapeutic Foster Care); and the number of trainings provided to expand implementation of EBPs statewide;
  -- Increased opportunities for consumer/family involvement in Person Centered Plans through Child and Family Teams; possible measure sources for tracking this would be NCTOPPS (North Carolina Treatment Outcomes and Program Performance System) and Local Management Entity performance reports; and
  -- Decrease in stigma; possible measures sources for tracking this would be the Divisions of Public Health and Social Services and Department of Public Instruction, where common outcomes are shared and measured.

Challenges/Needs Identified by Planning Council Members:

♦There is limited state funding for trainings; some trainings need statewide centralized integration, such as for the expansion of Crisis Intervention Teams. Law enforcement officers need incentives to persuade chiefs to "buy in" to such programs. Increased funding is needed for Crisis Intervention Team training; if this training is "watered down," there is the likelihood of losing fidelity to the model.

♦Consumer education is critical to reduce stigma. There is also a need for providers to have training/education about other local providers and what services they provide.

♦Local Management Entities need objectives that match the State Strategic Plan; Local Management Entity accountability is tied to the contents of their local business plan.

♦Gang activity is increasing in some parts of the state and this is another area that needs more attention by law enforcement.

♦As a result of paid claim reviews, it seems that some providers need to better understand the services being provided—how the services should look when delivered correctly.

♦Community capacity should be developed in other areas besides increasing local crisis services, such as expanding jail diversion programs or having step-down type services for people to go to when they leave Assertive Community Treatment Teams (ACTT).

•Training is needed for Peer Support Specialists and getting the proper education about their role is critical. The certification training for Peer Support Specialists is intense in North Carolina; other co-workers need to know what skills and abilities the Peer Support Specialist can bring to the team. We need to build in a recovery component for the Peer Support Specialist. They need on-going weekly support groups.
♦There should be more collaborative relationship-building between agencies and programs.
♦Uniformity should exist in consumer education/training and there should be incentives for people to realize the value/benefit of the training.
♦We need to look at ex-offenders who take on the role of Peer Support Specialists.
♦Some providers are having problems with cash flow.
♦Confusion exists over which services can be provided concurrently (e.g., Psychosocial Rehabilitation and Asssertive Community Treatment Team cannot be done together); if someone has the intensive need level for Assertive Community Treatment Team services, they would typically not be appropriate for Psychosocial Rehabilitation until level of need reaches that of the consumer being ready to "step down" to a less intensive service, such as Psychosocial Rehabilitation.
♦Improvement needs to be made in service delivery for older adult consumers with mental illness.
♦Disparity exists in funding across the three disability groups; substance abuse admissions are up in state psychiatric hospitals when these admissions should be going to Alcohol and Drug Abuse Treatment Centers (ADATCs).
♦Local Management Entities need to have disaster plans in place and the disaster coordination plans need to be integrated for all disabilities.
♦ Service access for those consumers in jail is another area of need (considering quantity and quality of service availability).
♦Consumers need help in navigating the system and accessing services.

For more details on the involvement of consumers and family members in advocacy type activities, please refer to the two page table in Appendix B of this Implementation Report, entitled, ***Summary of Existing Opportunities for Consumer and Family Involvement and Advocacy in North Carolina*** (updated June, 2006).

Following is a list of the North Carolina Mental Health Planning and Advisory Council members.

State Mental Health Planning Council Membership List and Composition

Name	**Type of Membership:**	***E-Mail Address***	**Address, Phone & Fax**
Beverly Varner	Families of Adults with Mental Illness		1718 Grove Street Greensboro, NC 27406 (336) 272-7543 (home) (336) 279-1003 (work)
Jeff McLoud, Chair	Adult Consumers with Mental Illness	Jeffmcloud@earthlink.net	1609 Dupree Street Kinston, NC 28504-3401 (252) 527-0640
Ed Seavey	Families with Children with SED	seaveys@bellsouth.net	50 Heath Drive Waynesville NC 28786 H: 828-452-1116
Libby Jones	Parents of Children with SED	Ljones3@bellsouth.net	5901 West Market Street Box 123 Greensboro, NC 27409 (336) 988-7874 (work)
Dorothy Best	Adult Consumers with Mental Illness	dbestmomentum@earthlink.net	20 A North Sussex Drive Smithfield, NC 27577 (919) 934-4149 (home) (919) 464-6512 (cell)
Katie C. Sawyer	Families of Adult Consumers with Mental Illness	katiesawyer@gotricounty.com	Post Office 275 Pantego, NC 27860 (252) 943-3870 (home) (252) 964-4900 (office)
Loretta King	Adult Consumers with Mental Illness		901 East Sixth Avenue Gastonia, NC 28054-5105 (704) 867-7460
Kelly Jones Nguyen	Parents of Children with SED	kellyenguyen@hotmail.com	2861 Morningdew Drive Sophia, NC 27350 (336) 317-1271
Frank Read	Families of Adult Consumers with Mental Illness	Fread@nc.rr.com	127 Jeffress Drive Louisburg, NC 27549 (919) 496-6224

Sheila Wall-Hill, Vice-Chair	Parents of Children with SED	parentvoiceswh@aol.com	8125 Nations Ford Road Charlotte, NC 28217 704-922-6335 (office) 704-529-4109 (home); 905-7016 (cell)

Name	**Type of Membership: State Employee**	**E-Mail Addresses**	**Address, Phone & Fax**
Mary Edwards	Division of Aging	mary.edwards@ncmail.net	2101 Mail Service Center Raleigh, NC 27699-2101 (919)733-0440
Dan Fox	Division of Vocational Rehabilitation	Dan.Fox@ncmail.net	2801 Mail Service Center Raleigh, NC 27699-2801 (919) 733-3364
Terri Shelton, Ph.D.	Professor of Psychology, University of NC at Greensboro (Ed.of MH Professionals)	shelton@uncg.edu	2005 Regents Park Lane Greensboro, NC 27455 (336) 288-8695 (home) (336) 217-9732 (office)
Laura White	Division of MH/DD/SAS	Laura.White@ncmail.net	3006 Mail Service Center Raleigh, NC 27699-3014 (919) 733-3654
Esther High	Division of Social Services	Esther.High@ncmail.net	Program Manager, Foster Care & Adoptions 2409 Mail Service Center Raleigh, NC 27600-2409 (919) 733-9464
Kaye Holder	Department of Health and Human Services	Kaye.Holder@ncmail.net	2002 Mail Service Center Raleigh, NC 27699-2002 (919) 733-3770
Diann Irwin	Dept. of Public Instruction Division of Exceptional Children	Dirwin@dpi.state.nc.us	6356 MSC Raleigh, NC 27699-6356 (919) 807-3298
Mary Reca Todd	NC Housing Finance Agency	Mtodd@nchfa.com	P.O. Box 28066 Raleigh, NC 27611 (919) 877-5672
Carolyn Wiser	Division of Medical Assistance	Carolyn.wiser@ncmail.net	2501 Mail Service Center Raleigh, NC 27699-2501 (919) 855-4296
Laura Yates	Division of Prisons	Mly02@doc.state.nc.us	4277 Mail Service Center Raleigh, NC 27699-4277

			(919) 733-3226

Name	Type of Membership: Providers	E-Mail Addresses	Address, Phone & Fax
Lucy Dorsey	Representative of Providers of Local Services for Children Sandhills Area Authority (Randolph)	Lucy.dorsey@sandhillscenter.org	Sandhills Center 110 West Walker Avenue Asheboro, NC 27203 (336) 633 7000 Fax (336) 625 3817
Densie Lucas	Representative of Providers of Local Services Children & Adults	Dlucas@mail.ccmentalhealth.org	106 Carmichael Lane Spring Lake, NC 28390 (910) 497-1227(H) (910) 323-0601x6878 (O)
Stan Oathout	NAMI North Carolina	stanleyoathout@aol.com	3240 Beaver Creek Dr., SE, Southport, NC, 28461 (910) 253-0863 (H) (910) 612-9584 (cell)
Mark Urban	Governor's Advocacy Council for Persons with Disabilities	mark.urban@ncmail.net	7105 Sandringham Dr. Raleigh NC 27613 919-395-8513
Gail Cormier	Families United	gcormier@triad.rr.com	3007 Scout Trail Jamestown, NC 27282
Emily Moore	NC Commission for MH/DD/SAS	jmoore@icomnet.com	3505 Lakeview Trail Kinston, NC 28504 (252) 522-2391 (H) (252) 522-1701 (Fax)
Tisha O'Neal Gamboa	NC MH Consumers' Organization, Inc	NCMHCOTisha@aol.com	5940 Presentation St. Knightdale, NC 27545 (919) 832-2285

Vendia Currie	Mental Health Association in NC	vcurrie@upscaleenterprises.com	614 N. Pine Street Roseboro, NC 28382 (910) 214-5398 cell, use 1st (910) 960-5398 office
Martin Pharr, Ph.D.	Ad Hoc/Ex Officio Member; NC Dept. Juvenile Justice & Delinquency Prevention	Martin.Pharr@ncmail.net	1801 Mail Service Center Raleigh, NC 27699-1801 (919) 733-3388

Service System for Adults with Serious Mental Illness

Criterion 1. Comprehensive Community-Based Mental Health Service Systems

Service System Organizational Structure

Historically, the organizational structure of the system of care for adults with mental illness in North Carolina was based on the delivery of community-based services provided by the local area programs. North Carolina is now changing the structure of the service system as area programs have become Local Management Entities that contract with providers for the services needed in the community. Funding to support mental health services is a combination of receipts from insurance and Medicaid, County funds, State funds, and Federal Mental Health Block grant funds. State and Mental Health Block Grant funds are earmarked for service provision to adults with serious mental illness and children with serious emotional disturbance. There is a contract between the NC Department of Health and Human Services (which includes the Division of MH/DD/SAS and the Division of Medical Assistance) and each Local Management Entity. The State monitors the Local Management Entities' compliance with the contract requirements and the Local Management Entities are responsible for monitoring their contract providers of service. Also, in terms of service delivery, the Division of MH/DD/SAS' organized community-based system of care does include services for people with co-occurring disorders to include adults with mental illness and substance abuse disorders. Many of the new enhanced service definitions are for individuals with a diagnosis of mental illness and/or substance abuse. Some of these include: Community Support, Community Support Team, Mobile Crisis Management, and Diagnostic Assessment, just to name a few.

Adult – Transformation Efforts and Activities Related to Criterion I:

The strengths, needs, and priorities discussed in other sections of both the Plan and this Report provide the context for the goals and objectives related to each Criterion.

Key values of mental health reform include improved access to services, consumer satisfaction with services, and services that contribute to positive outcomes. Crisis service plans are being developed in each Local Management Entity's catchment area on a statewide basis. Crisis services are designed for prevention, intervention, and resolution, and provided in the least restrictive setting possible, consistent with individual and family needs and community safety. Standardized training is being done around the state in "Accessing Care" for providers and Local Management Entities.

Goals pertaining to reduced admission and readmission rates to State Psychiatric Hospitals help gauge the successful reintegration of people returning to the community from state hospitals. The Division has been promoting readmission rates as active goals with each Local Management Entity over the last 12 months and it may be formally proposed that this become a part of the Local Management Entity performance contract.

Goals relating to Evidence Based Practice are tracked by the numbers of Evidence Based Practices available in North Carolina and the number of individuals receiving services through which Evidence Based Practices can be delivered. North Carolina's data system doesn't track Evidence Based Practice data as we depend on the service definitions for that. The number of Evidence Based Practices is anticipated to increase as more services are used as a platform from which the Practices can be delivered.

Goals pertaining to perception of care, increased social supports/connectedness, and satisfaction with care help gauge the consumer's perceptions regarding the outcomes of the care, perceptions about how the consumer's relationships have been enhanced by services received and whether the consumer felt services were responsive to his/her needs and preferences.

Goals relating to employment retention, decreased criminal justice involvement, and stability in housing are tangible goals that are indicative of services and supports helping consumers to remain more independent in the community. Improvement in consumer employment outcomes is one of North Carolina' five State Strategic Plan Objectives for 2007-2010.

Adult – Available Services

Health

According to the North Carolina Primary Health Care Association, there are currently 22 federally funded health centers operating in over 73 delivery sites around the state of North Carolina. Federally designated community health centers (CHCs) are safety net providers supported by the Bureau of Primary Health Care (BPHC) of the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services who must serve an increasing number of uninsured patients, despite limits on funding and other challenges.

Lack of access to medical care does continue to be a problem in North Carolina as is the case in many other states. The Behavioral Risk Factor Surveillance System, a random telephone survey of adults, was conducted in 2005 by the North Carolina Division of

Public Health, in cooperation with the Centers for Disease Control and Prevention and the State Center for Health Statistics; the findings of this survey were presented in a report entitled, *Health Risks Among North Carolina Adults: 2005* and the report was printed in October, 2006. In terms of health care access, based on survey responses, close to 1 in 5 North Carolina adults (19.1%) or an estimated 1.2 million adults, had no health insurance coverage in 2005. About 82% of Spanish-speaking Hispanics reported not having a personal doctor, nearly twice the rate of most other high-risk demographic groups. In fact, one alarming trend in North Carolina is the increase in uninsured adults. Lack of insurance has increased from about 13% in 2000 to about 19% in 2005 (mainly due to high rates of uninsurance among Spanish-speaking Hispanics). This survey does reinforce the point that much needs to be done to help people have access to needed health care in our State.

Community Care of North Carolina (CCNC) Mental Health Integration Pilot
The Division is involved in a pilot geared to integrating mental health and physical health needs. Several networks in the Community Care of North Carolina (CCNC) program began to see an increasing number of Medicaid enrollees at primary care provider practices with both behavioral and physical health care needs. As a result of efforts in the mental health reform and changes in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DDSAS) local management entities (LMEs) are piloting a collaborative approach to managing care for Medicaid enrollees who have both behavioral and physical health needs and serve them in the most appropriate setting. The mental health integration pilot is a state level collaboration between the Division of MH/DD/SAS, Medical Assistance and the Office of Research, Demonstrations and Rural Health Development (CCNC Program Office) and the North Carolina Foundation for Advanced Health Programs, Inc. The four community networks and LMEs involved in the pilot include: Access II Care of Western North Carolina and Western Highlands; Southern Piedmont Community Care Plan and Piedmont Behavioral Healthcare; Central Piedmont Access II and CenterPoint Human Services; and Partnership for Health Management and the Guilford Center.

Each network will work with both adult and pediatric populations using the Four Quadrant Clinical Integration Model as the foundation for communication, collaboration, assessment, referral and clinical management of care. Using CCNC's web-based case management system, the networks and Local Management Entity staff will be able to document and share information. To ensure that data collection is comparable across projects, common forms and tools have been developed including a telephone consultation form, behavioral health assessment form, case consultation request form, and provider surveys.

All networks are implementing a universal screening tool and clinical pathway for depression. In addition to these standardized elements the pilots are also demonstrating improved outcomes through the following: incentives to primary care providers to complete behavioral risk screenings; co-location of behavioral specialists with physical health primary care providers for service provision; improve communications across providers to improve access to and care provided; development of screening tools that

work well in primary care settings and apply evidenced based clinical behavioral health practices; consumer/patient education and coordinated transition planning; adoption of common measurements for program evaluation; and ongoing physician education, including case and pharmacology reviews between LMEs and Primary Care Providers.

The outcome and performance measures will be captured through the web-based case management system and through paid claims. In addition to tracking missed school or work days, no-show rates, medication adherence and patient reported functional status, information regarding the telephone consultations and screening tools will also be captured.

The lessons learned in the mental health integration pilots will be used to guide the formation of Medicaid mental health policy and assist in forming targeted statewide training and technical assistance. The infrastructure and models developed and implemented by the pilots will be able to support replication and expansion efforts in other networks and communities.

Mental Health Treatment Services

The "Action Agenda for Mental Health Reform" that was released by the Department of Health and Human Services in the spring of 2006 concentrates on three consumer focused areas over the coming year: 1) access to services, including crisis services; 2) assisting consumers in navigating the system; and 3) expanding continuous quality improvement processes. These areas are priorities of the Division as well and are reflected in the processes described below as the transformed system moves forward with improving access, helping consumers, and expanding quality improvement processes.

In terms of the Division's steps in improving service access and helping consumers in crisis, they are continuing the development of comprehensive crisis services. In fact, the continued development of comprehensive crisis services is one of five of the State's Strategic Plan: 2007-2010 main objectives. A comprehensive crisis service system is critical to stabilize the system across all disabilities state-wide. Such a comprehensive system must be prepared to meet the needs of any individual who experiences a crisis related to a mental health or substance abuse problem or a developmental disability. Such a comprehensive system must be prepared to provide appropriate services that are evidence-based or best practices. At the community level, a comprehensive crisis service system must be totally integrated with the existing community medical and public safety emergency response system.

While state facilities clearly have an important role in a comprehensive crisis service system, admission to a state psychiatric hospital should be the choice of last resort. All too often, individuals who experience such a crisis are quickly transported by police to hospital emergency rooms or to state operated psychiatric hospitals. Improved access to commitment evaluations and community resources serving as alternatives to state hospital admission are important in providing a comprehensive crisis system and in decreasing inappropriate state hospital admissions. Use of the state psychiatric hospitals or the alcohol and drug abuse treatment centers is quite appropriate when community

options are exhausted and a thorough crisis evaluation has ruled out all less restrictive community alternatives.

When existing consumers of the system have a fully developed person-centered plan, including a crisis prevention/intervention plan and an assessment of health risk and safety, the consumers, family members and first responders know what actions are needed to promote health, independence and safety; to prevent escalation of the crisis; and to intervene in a way that is appropriate for the person. Crisis prevention begins with a good risk assessment and a plan that anticipates the supports needed for the person in the eventuality that a crisis occurs. Often, the crisis can be resolved in a timely manner in the person's home community given a comprehensive array of crisis services. Training of first responders regarding crisis planning and management is also critical. Currently, individualized planning as person-centered plans, including crisis plans and transition plans, is not fully exercised statewide as intended.

Currently, each Local Management Entity (LME) has submitted a plan for developing comprehensive crisis services in its geographic area. As mandated by the North Carolina General Assembly, each plan must provide community crisis services for any person experiencing crisis due to a mental health or substance abuse problem or developmental disability. Further, the General Assembly appropriated funding for development of these services and for their ongoing operation. The Division contracted with consultants from Technical Assistance Collaborative, Inc. to assist with review of plans and provision of technical assistance to Local Management Entities in their implementation through June 2008.

Screening, Triage, and Referral services are critical and one of the initial goals of this process is to determine if the consumer is experiencing an emergent situation requiring an immediate response. Standardized *Accessing Care* training was begun in late SFY 2007 and is continuing into early SFY 2008 for providers and Local Management Entities.

In regards to the expansion of continuous quality improvement processes, the North Carolina Treatment Outcomes and Program Performance Systems (NC TOPPS) is a way to capture consumer progress. Data gathered from this performance and outcomes monitoring system is used to provide the State with recommendations and important benchmarks from which to develop clear, measurable goals for substance abuse and mental health treatment. The purpose of this tool is to integrate performance and outcome monitoring into the ongoing operations of Local Management Entities and their provider agencies and work toward the establishment of a quality management approach which is sensitive to consumer behavior and assesses changes (i.e., improvement or non-improvement). Another recent project of the Division's Quality Management Team has been to display "Quality Quick Facts" on the Division's public website; the goal is to engage and inform web visitors regularly about the progress of the public system of services to people with mental illness, developmental disabilities and substance abuse. Each month a different topic of interest is highlighted and links are provided for more information.

Psychosocial Rehabilitation Services
These services are available through providers throughout the state. The most widely available model provides programming for at least five hours a day and is designed to assist clients regain or develop the skills needed for success in the community. Examples of these skills include: housekeeping, shopping, cooking, use of transportation, money management, grooming, health care, medication management, social relationships, use of leisure time, and educational activities. In addition, there is assistance available for consumers to develop positive work habits and prepare for employment. However, if the Psychosocial Rehab provider organization also provides Supported Employment or Transitional Employment, these services are to be costed and reported separately. Members of the Mental Health Planning Council have indicated that this type of rehabilitation service and peer support services contribute greatly to consumers' success in the community.

Supported Employment Services
Most adults with serious mental illness want to work. However, many of them need training, assistance and on-going service support in order to find and keep a meaningful job. One of the priorities of the Adult Sub-Committee of the Planning Council has been to gather information on the collaborative efforts that offer such support. Local units of the Division of Vocational Rehabilitation Services (DVRS) and Local Management Entities (LMEs) associated with the public mental health system collaborate at the community level to enable individuals with serious mental illness to achieve successful vocational outcomes**.**

Supported Employment services are available through the state-funded definition or through providers who choose to contract with the Division of Vocational Rehabilitation Services as Supported Employment vendors. For those who receive Supported Employment from the Division of Vocational Rehabilitation Services, that Division funds the up-front, intensive training portion of supported employment while the Division of MHDDSAS is responsible for the costs of long term vocational supports. At the state level, the two agencies joined representatives from other stakeholder groups (at the Supported Employment Workgroup) to address issues related to the seamless delivery of supported employment services. The two agencies developed a state level memorandum of agreement which outlined the responsibilities of each agency related to supported employment services and other employment related service options and this has been approved and signed by Directors from both Divisions. In addition, representatives from the state offices of each agency collaborated with other stakeholders in Winston-Salem to discuss how to begin to implement evidence-based Supported Employment in that community, and it is hoped that the groundwork performed by this group will assist other communities to develop such programs.

As stated above, North Carolina is beginning to use evidence-based models of service throughout its service delivery system. The Division is committed to revising the Supported Employment definition to make it more evidence-based in scope and plans are being made to begin that process. Documentation of Supported Employment as an evidence-based practice is well noted in the literature. It will consist of the following

essential elements: focus on and commitment to competitive work; rapid job search and placement; de-emphasis on pre-vocational training and assessment; attention to client preferences; individuals who desire to work will have an opportunity for employment, regardless of their disability or skills; follow-along supports provided indefinitely; and integration with case management and clinical services.

Funding was allocated to the Local Management Entities beginning in SFY 2005-06 and again in SFY 2006-07 to cover the cost of Long-Term Vocational Support Services provided to consumers who had successfully completed Supported Employment, had stabilized on their jobs, and needed the on-going support afforded by this long-term service to help maintain their employment.

The Second Annual Congress of the North Carolina Practice Improvement Collaborative has recommended that the Division adopt the Evidence-Based Practice of Supported Employment for consumers with mental illness. The Collaborative was formed in 2005 to provide guidance in determining the future evidence based services and supports that will be provided through our public mental health/developmental disability/substance abuse service system. Sixty people were appointed to serve as advisors to the Division, and membership is comprised of consumers or family members, clinicians and researchers.

The Division recognizes the value of employment in recovery to those with mental illness and has included employment as one of five major objectives in the new State Strategic Plan for 2007-2010. The goal, as stated in the Plan, is to improve consumer outcomes related to education and employment.

Housing

Providing safe, affordable housing for persons receiving mental health, developmental disabilities and substance abuse services is critical to the successful transformation of North Carolina's mental health system. For many years, the Local Management Entities (LMEs) have been working to find ways to increase the availability of and access to housing for adults with mental illness.

Since the mid 1980's, significant amounts of housing has been developed in North Carolina that has been funded by the Federal Housing and Urban Development. The HUD Section 811 program makes capital advances to finance the development of rental housing and group homes with the availability of supportive services for persons with disabilities. The advance is interest free and does not have to be repaid as long as the housing remains available for very low-income persons with disabilities for at least 40 years. Project-based rental assistance covers the difference between the HUD-approved operating cost of the project and the tenants' contributions toward rent and utilities (usually 30 percent of monthly adjusted income) in the rental housing units.

In fall 2005, the first rental assistance payments from the NC Dept of Health and Human Services and the NC Housing Finance Agency's Key Program were made. The Key Program provides an operating subsidy in the form of rental assistance for persons with

disabilities in targeted Low-Income Housing Tax Credit units. The Key Program is jointly funded by the NCHFA' HOME Match funds and the Mental Health Trust Fund.

In July 2006, the North Carolina General Assembly created a new endeavor called the "Housing 400 Initiative" that builds on the partnership between the NC Dept. of Health and Human Services, the NC Division of MH/DD/SAS and the NC Housing Finance Agency. This Initiative is designed to increase the supply of "independent and supportive living apartments for persons with disabilities" that are affordable to persons with incomes at the level of Supplemental Security Income (SSI).

To make this goal a reality, $10,937,500 was allocated to the North Carolina Housing Finance Agency (NCHFA) for the development of rental housing and $1,205,000 was allocated to the North Carolina Department of Health and Human Services (DHHS) to provide rental assistance for the 400 units financed by NCHFA under the Initiative. The capital funds are available through two programs: The Housing 400 Initiative Supportive Housing Development Program (SHDP 400) and the Housing 400 Initiative Preservation Loan Program (PLP 400). In addition to the capital expenditures, the Housing 400 Initiative will fund up to 250 targeted units with Key Program assistance through the LIHTC development program. Currently as part of these housing initiatives, there are 495 units that will be developed and targeted to serve persons with disabilities and additional funding was appropriated by the 2007 session of the NC General Assembly to continue and expand both rental assistance and capital expenditures.

The Division of MH/DD/SAS is undertaking a major objective to improve consumer outcomes related to housing as part of a Three Year Strategic Plan. The main action steps will include: 1. Involve consumers in promoting the aspects of the communication plan (developed in the objective on the provider system) that emphasizes the role that stable housing plays in treatment, recovery and/or full inclusion in the community; 2. Develop strategies for implementing the Division's long-term integrated housing plan and build upon the mental health/developmental disabilities/substance abuse Commission's housing recommendations with revisions as needed; and 3. Develop guidance and provide additional training and support to Local Management Entities' (LMEs') housing specialists to increase knowledge and skills in all options regarding housing for consumers of mental health/developmental disabilities/substance abuse services**.**

North Carolina also continues to support Housing Specialist positions based in 17 Local Management Entities to promote the expansion of local housing expertise and development capacity.

Educational Services

Specific to services, all service providers provide information for consumers that include medication education and information about their rights as users of the mental health system. Many Local Management Entities also provide some information and education for families of adults with serious mental illness. In addition, The North Carolina Chapter of the National Alliance on Mental Illness provides an educational program called *Family to Family*. The North Carolina Mental Health Consumers Organization

puts out a newsletter four times per year in which the organization aims to educate consumers about their rights and services available.

The Mental Health Association in NC will continue to operate a call center that will be able to provide information about how to access services. This call center will have the capacity to respond to non-English speaking callers. In addition, this organization will also be reaching out to special populations including the Deaf community; the Hispanic/Latino community; and the faith community.

Consumers with serious mental illness also may have access to educational opportunities through participation in a psychosocial rehabilitation program. Examples include courses designed to prepare the individual to obtain a General Education Diploma (GED) or to enroll directly in courses offered by the local community college. In addition, the Division of Vocational Rehabilitation offers assistance to consumers in the form of initial training for new employment.

An annual Geriatric Mental Health Conference is sponsored each year in partnership with "NC CARES," a geriatric training component of the University of North Carolina, School of Social Work. Conference topics typically include information about losses adults face through the aging process, treatment of loss/grief issues and incorporating creativity into practice. This conference is designed to educate and train hospital staff as well as community mental health workers on current issues related to the elderly population. The Division's Geriatric Coordinator is serving on the Planning Committee for the 2007 Geriatric Mental Health Conference. This will ensure that conference sessions are pertinent to mental health professionals working with older adults.

North Carolina Mental Health/Adult Geriatric Specialty Team

A need for greater local capacity to address the needs of older adults with mental illness was recognized as plans were developed to increase community capacity to serve older adults and to reduce reliance on State hospital services in SFY 02-03. At that time, funding was provided to develop twenty community-based mental health geriatric specialty teams that would be available to provide expertise and services throughout the State. In January, 2007 another team member was added to address the needs of younger people with mental illness residing in long term care facilities. The name of the team was changed to the Mental Health/Adult Geriatric Specialty Teams. **Update:** Each of the 20 Mental Health/Adult Geriatric Specialty Teams received an additional $35,000 in funding in January 2007 and another $35,000 in July 2007.

Purpose:

The purpose of these teams is to increase the ability of people with mental illness to live successfully in their communities by providing consultation, education, training and technical assistance to staff and caregivers at nursing homes, adult care homes, family care homes, and caregivers that serve individuals who have mental health needs and who are at risk of psychiatric hospitalization. The teams do not provide direct services to individuals residing at the different facilities, home or agencies but do provide consultation to the staff and caregivers of the individuals.

Team Description:

Minimally, the teams consist of three team members, a registered nurse and a master's prepared therapist, both preferably with experience working with the target population and a Qualified Mental Health Professional with experience working with younger adults living in long term care facilities. Services are not usually provided in an office setting, but rather at the facility the team is working with. Team members may perform some activities together when the situation calls for the professional skills of more than one team member.

Target Population:

The teams serve the following targeted populations:

1. Nursing home, adult care home or family care home staff serving individuals who are 60 years of age or older with mental illness. These can be facilities identified during discharge planning for individuals who are in a state psychiatric hospital preparing to return to the community or facilities currently serving older adults with mental illness.
2. Caregivers who are serving individuals in their residential home who are 60 years of age or older with mental illness and at risk for psychiatric hospitalization.
3. Nursing home, adult care home, family care home staff or caregivers serving individuals younger than 60 yrs of age with mental illness that have geriatric like symptoms/needs such as individuals with dementia.

Team Activities:

Examples of the types of activities the team may provide to assist with the successful reintegration of older adults into the community when they are discharged from State psychiatric hospitals include, but are not limited to, the following:

- provide training, education and consultation to the staff of the residential facility to which the individual is going to be discharged to on issues specific to that individual;
- provide crisis-oriented face-to-face or phone support to the staff or caregivers during normal work hours to assist the staff via instructions with implementation of the crisis plan and to help ensure the agency responsible for first responder is notified if crisis plan is unsuccessful in diffusing the crisis.
- provide information to AP/LME and state hospital regarding strengths and capabilities of nursing homes and adult care homes for individual discharge planning;
- assist in discharge planning with hospital staff, assigned mental health service provider and LME as a support to the planning process by providing resource information on rehabilitative services and/or residential setting that are needed by the individual;
- assist the hospital staff, assigned mental health service provider, LME and residential staff in the development of a crisis plan specific to the individual and train the staff on strategies to implement the crisis plan;

Examples of the types of activities the team may provide to assist nursing homes, adult care homes, and family care homes or caregivers/families that serve individuals who have

mental health treatment needs and who may be at risk of psychiatric hospitalization include, but are not limited to, the following:

- provide training and education to the staff and caregivers on various topics relevant to older individuals with mental illness;
- provide case consultation with staff regarding behaviors that may result in need for more intensive services including and up to hospitalization;
- provide input and support in the development of intervention plans;
- model for staff appropriate implementation of intervention plans as needed;
- review medication regimen and educate staff in communication with psychiatrist, physician and pharmacist;
- educate facility staff, other agencies and families on issues and such topics as recognizing symptoms of mental illness, behavioral interventions, communication issues, and medication issues;
- establish linkages with community providers serving the geriatric population for the purpose of increasing community opportunities for the gero-psychiatric population;
- provide resource information and identify ongoing training resources for staff.

Substance Abuse Services
North Carolina's public substance abuse system is integrated as a part of the responsibility of the Division of MH/DD/SAS and provides community-based services including education, prevention, early intervention and the full spectrum of ASAM (American Society of Addiction Medicine) treatment services to the state's residents.

North Carolina policy recognizes that all services for adults with a co-occurring mental health and substance abuse service needs should be addressed in an integrated manner. Adult mental health has primary responsibility for consumers who have both a serious mental illness and substance abuse. The North Carolina Practice Improvement Collaborative was formed in 2005 by the Division Director to provide guidance in determining the future evidence based services and supports that will be provided through our public system. Early in their work this group recommended addressing the needs of people with co-occurring mental illness and substance abuse. A grant funded pilot project has been carried out to explore and implement changes in local administrative functions that will facilitate implementation of integrated dual disorder treatment as an effective evidence based practice.

Medical and Dental Services
Consumers usually obtain medical and dental services from private practitioners in their community. If unmet medical or dental needs are identified, case managers are expected to assist the consumer to obtain the needed treatment or dental care. Between thirty and sixty percent of adult consumers have Medicaid, which reimburses physicians and dentists for their services. An additional group of adult consumers have Medicare coverage and the North Carolina Medicaid program covers the cost of purchasing Medicare Part B (outpatient medical services) for them. In addition, preventive medical and dental services are provided in a number of local communities through local public health departments and community health centers, located in rural areas.

According to the North Carolina Primary Health Care Association, there are currently 22 federally funded health centers operating in over 73 delivery sites across the state of North Carolina. Access to health services is essential for physical well being. This is especially true for adults with serious mental illness who need only treatment for physical illness and for many of whom also need access to preventive services such as weight management and monitoring of their risk for diabetes. The Division is critically aware of the need to have greater collaboration with the medical community in moving toward the integration of physical health and mental health services. Education will play a critical role in this incorporation of family physicians, local hospitals, psychiatrists, and other private service providers.

Support Services
Adults with serious mental illness often need assistance to obtain benefits and to gain access to services and activities that are available in their community. Others may need help coordinating services and developing specific skills. North Carolina's Person Centered Planning process will result in increased attention to all aspects of individuals' needs and preferences. Person-centered planning provides for the individual with the

disability to assume an informed and in-command role for life planning, treatment, service and support options. For all individuals receiving services, it is important to include people who are important in the person's life such as family, legal guardian, professionals, friends and others as identified by the individual (i.e., employers, teachers, faith leaders, etc.). These individuals can be essential to the planning process and help drive its success. When agency staff, policy makers and funders value and monitor such outcomes as individual satisfaction, community integration, quality of life and achievement of individualized goals, the resulting plan is much more likely to be one that is strengths–based and recovery-focused.

Recovery Focus and Peer Support

The recovery philosophy and consumer empowerment are key components of mental health reform. The importance of active consumer involvement is clear as exemplified by consumer-run support groups and consumer participation in a wide variety of groups, such as the Consumer and Family Advisory Committees. The certification process for Peer Support Specialist has been implemented. Opportunities for the development of peer run services is being discussed and opportunities for consumers to be part of the staff who are providing mental health services is a reality, as in the provision of such services as Assertive Community Treatment Team, Community Support Team, and Social Setting Detoxification. Members of the Mental Health Planning Council clearly support efforts to recognize and implement this within the ongoing reform of the mental health system in North Carolina and have had training by a Disability Rights Specialist on consumer directed supports.

Services Provided by Local School Systems Under the Individuals with Disabilities Education Act (IDEA)

Several changes were effected in the reauthorization of IDEA and the state's response to its implementation. Most importantly, the age for addressing transition and vocational needs of youth in NC remains at 14 years (vs. federal minimum standard age of 16) through now 21 years of age or up to the 22nd birthday. Work continues with the state education and local education agencies and also with the Departments of Workforce Development and Commerce as well as with the Division of Vocational Rehabilitation Services to assure that appropriate accommodations are provided for youth in transition and young adults who are eligible under IDEA and/or who meet eligibility under ADA (Americans with Disabilities Act). Initial discussions and opportunities to provide training and support to Community College staff who work closely with many of these youth as they transition from a free and appropriate public school education (FAPE) to self-disclosure and acquiring necessary accommodations to support their ability to learn and become engaged in competitive employment.

Case Management

Case management has been a required service and included in North Carolina's state funded service array since 1984. Since 1989, the State Medicaid Plan has covered case management services that are targeted to adults with serious mental illness if they need assistance with two or more of the following: educational, vocational, social, communication, financial, physical health (including medical and dental health), residential, recreational services or opportunities or with basic life skills. With the approval of the Community Support service definition in 2006 by the Centers for

Medicare and Medicaid Services, the case management function has become an integral part of that and other services.

The State also supports training for community based staff that provide case management for adults with serious mental illness. In addition, since 1987, the Division has sponsored an annual statewide conference which focuses on new developments related to case management. The annual conference has changed as the service definition has changed. On November 7-9, 2006, the 19th Annual Statewide Community Support/Targeted Case Management Conference was held in Winston-Salem, NC. Over 1100 participants attended; the Conference theme was "Implementing Change: Skills and Strategies for Success."

Services for Persons with Co-Occurring Disorders (substance abuse/mental health)
Co-occurring disorders were treated as multiple primary disorders with the implementation of the *North Carolina State Plan 2005*, in which each disorder received specific and appropriately intensive integrated treatment. Essential services for these consumers include comprehensive assessment, detoxification as necessary, community support, counseling through intensive outpatient programs, education, consultation, monitoring of medication and substance use, relapse prevention planning, and crisis management planning. North Carolina participated in the Co-occurring Policy Academy and has developed and begun implementation of an Action Plan for co-occurring disorders.

Cultural Competence
North Carolina recognizes the critical need to provide culturally competent mental health services. This value is incorporated throughout the current State Plan which guides mandated system reform efforts. North Carolina is addressing cultural competency and health disparities through the development of best practice guidelines, protocols, training and state-level and Department-level planning efforts. State-level planning efforts include Division participation in the Minority Health and Advisory Council of the North Carolina Office of Minority Health and Health Disparities. The goal of this group is to improve access to public health services for racial, ethnic and under-served populations. Planning efforts through the Division's Cultural Competence Advisory Group (CCAG) have included the development of a cultural and linguistic competency action plan. The plan addresses linguistic competence and includes monitoring and updating staff language skills, having provider and service directories available in key languages, getting assistance from the Division in helping organizations to obtain educational materials translated into identified languages, as well as having the Division to secure training materials for clinical staff in the use of interpreters. This group provides the background and a framework for future recommendations to the Division, Local Management Entities, service providers, and other stakeholders on the delivery of culturally and linguistically competent services for consumers.

Other Activities Leading to Reduction of Hospitalization:
Jail Diversion Services
Mental health, law enforcement and correctional officials in North Carolina increasingly agree that jails and prisons are not viable alternatives for people with mental illness, and

that community-based mental health treatment is a more efficient and effective way to help people with mental illness and justice system involvement.

Efforts to develop jail diversion services in North Carolina began in SFY 99-00 with funding provided to four area programs (Blue Ridge, New River, Piedmont, and Pathways). In SFY 00-01, an increase in the Federal Mental Health Block Grant made it possible to provide funding to six additional jail diversion projects (Rockingham, Mecklenburg, Guilford, Southeastern, CenterPoint, and Orange-Person-Chatham). In SFY 02-03 Federal Mental Health Block Grant funds made it possible to develop two new jail diversion projects (VGFW and Randolph). In SFY 04-05, SFY 05-06, and SFY 06-07, the twelve jail diversion projects continued under the administrative supervision of the Justice Systems Innovations Team in the Community Policy Management Section of North Carolina's Division of MH/DD/SAS.

Various models of jail diversion have been implemented in North Carolina. Pre-booking jail diversion programs in North Carolina include a police-based initiative modeled on the highly successful Crisis Intervention Team (CIT) approach first developed in Memphis, TN. There are now four different CIT training programs in North Carolina, and more than 400 law enforcement officers representing more than twenty-four (24) agencies have become certified as CIT officers. Federal Mental Health Block Grant funds were used to help evaluate the success of the first CIT program in North Carolina. Planning efforts are currently underway to establish CIT programs in many more counties in the state. Also, North Carolina's first statewide CIT conference is scheduled for November 2007.

In addition, there are fourteen (14) post booking jail diversion programs in North Carolina, twelve of which receive MHBG funds. These include four mental health court programs, one of which is funded through the MHBG allocation.
All state and federally funded jail diversion programs were required to submit outcome data. These outcome data were analyzed and a jail diversion statistical report was produced in SFY 03-04. A follow-up report that examined hypotheses suggested by the SFY 03-04 jail diversion statistical report was produced in SFY 04-05. These two reports are available on the NC Division's jail diversion website at the following address: http://www.dhhs.state.nc.us/mhddsas/justice/jaildiversion/index.htm.

The consumer outcomes database for jail diversion has been merged with North Carolina's Treatment Outcomes and Program Performance System (NC TOPPS). Future jail diversion statistical reports will rely on data available on consumers of jail diversion services through the NC TOPPS and other NC Division of MH/DD/SAS databases. A statistical report based on these data is being produced.

NC Mental Health Trust Fund to Increase Community Capacity

The North Carolina General Assembly established a Mental Health Trust Fund in SFY 01-02. These funds have been used each year to provide one time start-up funding to increase community service capacity. For example, in SFY 06-07, the Division issued requests for applications from Local Management Entities in collaboration with contracted service providers to fund projects designed to assist with one-time non-

recurring needs in SFY 06-07 and 07-08 related to the provision of community services to consumers. Initiatives that were funded included increasing local capacity to address the service needs of adults with mental illness, children with substance abuse, and adults with substance abuse.

State Mental Health Trust Funds were also used to fund a three year pilot project to address homelessness for people with disabilities by partnering staff devoted to the development of housing options with Assertive Community Treatment Teams and Community Support Teams. The combination of housing emphasis with treatment has been proven to be effective in other areas of the country.

Criterion 2. Mental Health System Epidemiology

Adult – Estimate of Prevalence

Definition and Prevalence of Serious Mental Illness

Adults who have severe and persistent mental illness are a subset of those with serious mental illness, which includes 2.6% of the adult population according to the document "Decision support 2000+." In North Carolina, priority funding of mental health service is given to adults who have severe and persistent mental illness. The NC General Statutes define severe and persistent mental illness as "a mental disorder suffered by persons of 18 years of age or older that leads these persons to exhibit emotional or behavioral functioning that is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long term or indefinite duration. This disorder is a severe and persistent mental disability, resulting in long-term limitation of functional capacities for the primary activities of daily living, such as interpersonal relations, homemaking, self-care, employment, and recreation."

Approximately 5.4% of the adult population in North Carolina has a diagnosable mental health disorder that meets the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria accompanied by serious role impairment that has lasted for at least twelve months. Based on the projected estimate of adults age 18 and above for 2003, about 343,217 North Carolinians have severe mental illness (SMI). With a +/- 0.9% margin of error, the number ranges from 228,092 to 456,183. About 2.6% (164,733 North Carolinians) are estimated to have severe and persistent mental illness (SPMI). The percentage of adults estimated to have any 12-month DSM disorder is 23.9% (or 1,519,055 North Carolinians). The estimates are based on a methodology established by a panel of experts convened by the federal Center for Mental Health Services.

A study conducted in 2001 by the National Household Survey on Drug Abuse (NHSDA) calculated the 12-month prevalence of serious mental illness as 7% (about 444,912 North Carolinians).

Estimates of the prevalence of substance abuse in persons with severe and persistent mental illness vary widely, from 10% to as high as 65%. This variation can be explained by differences in sample populations among the various studies. However, approximately half of all adults with severe and persistent mental illness have had a substance abuse disorder at some point in their lives and between 25% and 35% have a current co-occurring substance abuse disorder.

Adult – Quantitative Targets

Treated Prevalence

The following tables show the trend in the number of adults who received mental health services in the past three years. Actual demographic data for adults served during SFY07 follows:

Number of Adults Who Received Mental Health Services

Provided by Area Mental Health Programs

Year	Number Served
SFY 04-05	181,771
SFY 05-06	185,674
SFY 06-07	180,814

Nationally and in North Carolina, cultural and linguistic diversity is a growing challenge for mental health and health care delivery systems. During the last decade the number of people in need of services who have limited English proficiency has risen dramatically.

For example, between 1990 and 2000, the Spanish speaking Latino population in North Carolina grew by almost 400%, giving North Carolina the fastest growing Latino population in the country. According to the 2000 United States census, approximately half of North Carolina Latinos have limited English proficiency or are unable to speak English well. Such language barriers can impair a Latino's ability to access needed programs and services, and many are not knowledgeable about how the U.S. health care system works.

According to the actual data for SFY 2006-07, there was a total of 4,156 adults served through area programs who were identified as Hispanic; this is an increase over the numbers served during SFY 2005-06 (4,126), SFY 2004-05 (3,174), and SFY 2003-04 (2,628). However, since approximately 5 percent of the residents of North Carolina are Hispanic, these data reflect a need for mental health service providers to examine barriers that residents who are Hispanic may encounter when seeking services. Many area programs are attempting to hire Spanish speaking staff, but others still rely on using interpreters when providing services.

Data reflecting the race, age, and gender of adults served through Area Programs in SFY 06-07 are shown on the following page.

Adults Who Received Mental Health Services in SFY 06-07 Provided by Area Programs Compared to State Demographics : Race*

	Census # adults	Census Percent	# of Adults Served	Percent of Total served
White	4,527,155	74.40%	117,450	65%
Black/African American	1,218,470	20.00%	52,876	29%
Am. Indian/Alaskan Native	69,522	1.10%	2,442	1.35%
Asian/Pacific Islander	85,539	1.40%	741	.41%
Other, 2 or more races or unknown	184,580	3.00%	7,305	4.04%
TOTAL	6,085,266	100%	180,814	100.00%

Based on the USA Statistics in Brief—Census 2000 Resident Population of States.

Please note: Adults of Hispanic or Latino origin are not included in this table as a separate category as this descriptor refers to ethnicity (not race).

Adults Who Received Mental Health Services in SFY 06-07 Provided by Area Programs Compared to State Demographics : Age

	Census # adults	Census Percent	*# of Adults* Served	Percent of Total served
18-20	331,474	5.46%	15,987	8.84%
21-64	4,771,403	78.58%	153,206	84.73%
65 and over	969,048	15.96%	11,621	6.43%
TOTAL	6,071,925	100.00%	180,814	100.00%

Adults Who Received Mental Health Services in SFY 06-07 Provided by Area Programs Compared to State Demographics: Gender

	Census # adults	Census Percent	*# of Adults* Served	Percent of Total served
Female	3,148,696	51.74%	102,625	56.76%
Male	2,936,570	48.26%	78,189	43.24%
Not Available			0	
TOTAL	6,085,266	100.00%	180,814	100%

Adult – Transformation Efforts and Activities Relating to Criterion II
Activities related to this Criterion include goals that increase access to community based services, and provide specialized services such as by the North Carolina Mental Health/Adult Geriatric Specialty Teams (formerly known as the Geriatric Specialty Teams) and jail diversion services. Information about the number of adults who are receiving services will be followed closely. Providing services in convenient locations and times, that are staffed so that consumers are seen as needed, that service requests are responded to in a timely manner, and that all of the needed services can be obtained are inherent components of assuring access to services for adults with serious mental illness.

As discussed in other sections of this report, North Carolina's Mental Health/Adult Geriatric Specialty Teams increase the ability of people with mental illness to live successfully in their communities. This is done by providing consultation, education, training, and technical assistance to staff and caregivers at nursing homes, adult care homes, family care homes, and caregivers who serve individuals with mental health needs and who are at risk of psychiatric hospitalization. In January, 2007, another team member was added to address the needs of younger people with mental illness residing in long term care facilities. There are 20 Mental Health/Adult Geriatric Specialty Teams serving North Carolina's 100 counties.

Twelve Local Management Entities in the State receive Mental Health Block Grant funding to provide jail diversion services. This goal's activities help reduce the number of adults with serious mental illness who risk being arrested or who are in jails by providing outreach and community based services. Various models of jail diversion have been implemented in North Carolina. Pre-booking jail diversion programs in this State include a police-based initiative in Wake County modeled on the highly successful Crisis Intervention Team (CIT) approach first developed in Memphis, TN.

Below are some population groups identified by the Division as needing increased access to appropriate services:

~Services for Persons Who Are Deaf, Hard of Hearing, and Deaf-Blind
North Carolina has provided specialized mental health and substance abuse services to persons who are deaf, hard of hearing and deaf-blind since 1992. A total of 20 clinical positions are funded by the Division to provide specialized services to persons who are deaf, hard of hearing or deaf-blind. These positions are placed in strategic locations to provide regional coverage throughout North Carolina. Clinicians working in these positions are sign language fluent and understand the mental health needs of this population.

The State continues to target persons who are deaf, hard of hearing or deaf-blind for specialized mental health and substance abuse services. This population benefits from the current array of mental health services provided in the community (e.g., community support, individual psychotherapy). While regional clinicians provide the majority of direct services to the target population, some services are provided by provider agencies. Beginning 7/01/07, when sign language interpreting services are needed to make mental

health services sign language accessible, the Division will reimburse interpreters directly rather than reimbursing interpreters through the Local Management Entities.

Specialized services for persons who are deaf, hard of hearing or deaf-blind include but are not limited to an adult inpatient unit at Broughton hospital, a six-bed group home in Morganton, three one-bedroom apartments for deaf mentally ill adults in Wilson, four one-bedroom apartments for deaf mentally ill adults in Raleigh and accessible adult care homes statewide. In FY 07-08, the Division will continue its consultation with State, County and non-profit organizations on the development of domestic violence resources for victims of domestic violence who are deaf, hard of hearing or deaf-blind.

The Division consults regularly with the state residential schools in Morganton and Wilson that serve children who are deaf. The Beacon Center in Wilson and the Foothills Local Management Entity in Morganton are assigned clinical positions to provide direct services to children attending these schools. In SFY 07-08, the Division will continue to work closely with the Department of Health and Human Services Office of Education Services to plan and assure that language accessible and clinically appropriate mental health services are available to residential school students.

The Division works closely with consumers, advocacy groups, state and county agencies, provider organizations, and family members to ensure services continue to meet current needs. Further, the Division continues its long commitment to working with and listening to the community by assembling the Mental Health Advisory Council for the Deaf and Hard of Hearing each Quarter of the calendar year.

~Older Adults with Serious Mental Illness

The number of people age 65 and over is increasing rapidly. Between 1990 and 2000, the number of persons in North Carolina who were 65 and over increased by 20% from 804,341 to 969,048 (represents 12% of the State's residents). These numbers are expected to rise rapidly as "baby boomers" approach retirement. Additional community based mental health services to this population are needed to provide outreach and treatment to older people who are mentally ill as well as to provide consultation to other caregivers such as nursing homes, health care providers, and social service providers. Increased capacity to serve older adults in the community is critical in order to reduce the likelihood of greater demand for inpatient treatment services. The Division's Geriatric Coordinator is serving on the Planning Committee for the 2007 Geriatric Mental Health Conference. This will ensure that conference sessions are pertinent to mental health professionals working with older adults. Please note: information relating to the North Carolina Mental Health/Adult Geriatric Specialty Teams is discussed in detail in the previous section of this report, entitled, *Recent Significant Achievements*.

In an effort to provide opportunities for Planning Council members nationwide to learn about effective outreach for older adults with mental illness, the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services State Planning and Systems Development Branch, sponsored a 2-day conference in April 2007 in Bethesda, Maryland, entitled, "*Making the Mental Health System Work for Older*

Adults with Mental Illness." The Planning Council representative from the North Carolina Division of Aging and Adult Services, attended this conference and reported back to the Council with a detailed handout and pertinent information.

~Adults Who Have Serious Mental Illness and Who Do Not Have Safe, Affordable Housing

The affordable housing crisis that faces all low income North Carolinians is most acute for those with the least ability to compete in the market. Though much has been accomplished in increasing the amount of housing available and affordable to adults with serious and persistent mental illness, efforts at maximizing existing resources and advocating for new funding and inclusionary development policy is ongoing. More information on housing is available in the Plan section entitled, "Adult – Available Services."

~Adults Who Have Serious Mental Illness and Who Are Unemployed, But Who Want to Work

People with disabilities confront many barriers as they seek meaningful employment. Training is being done with providers around the State on evidence-based practices, which integrates best research evidence with clinical expertise and consumer values. Evidence-based practices, such as Supported Employment, focus on employment being a critical component of an individual's recovery. It is also important that we continue to use our psychosocial programs to support individuals as a way to obtain skills needed for gainful employment. Staff from the Division of Mental Health/Developmental Disabilities/Substance Abuse Services and the Division of Vocational Rehabilitation Services drafted a revised Memorandum of Agreement regarding expansion of cooperative efforts around employment and this was approved and signed by both Division Directors in early spring 2007. Increasing employment opportunities for consumers around the State is one of the Division's five major objectives in its State Strategic Plan for 2007-2010.

Criterion 3. (not applicable for adults)

Criterion 4. Targeted Services to Rural and Homeless Populations

Adult-Housing and Homelessness, Including Transformation Activities Related to Criterion IV

Data from the Emergency Shelter Grants Program showed that from July 1, 2006 to December 31, 2006, 25,775 unduplicated individuals were homeless. This is not including those persons unsheltered or living in shelters not receiving Emergency Shelter Grant funds. It is estimated that at least 30,000 individuals are homeless and at least 15,000 have a diagnosis of mental illness and/or substance abuse issues.

Specific activities and efforts related to this goal involve providing outreach and services to people who are homeless. Numbers of homeless people are tracked who receive mental health services supported by Programs for Assistance in Transition from Homelessness (PATH) funding. This is a Federal grant program, administered by the state that provides assertive outreach to individuals who are literally homeless, mentally ill, or mentally ill

with co-occurring substance abuse who are not in treatment. The local PATH sites coordinate services closely with other community programs providing services to homeless individuals. Coordination takes place with programs such as homeless shelters, soup kitchens, rescue missions, Salvation Armies, area program supportive housing programs, the Housing and Urban Development's Shelter Plus Care program, the Veterans Administration Medical Centers, and Homeless Veterans Programs. Addressing the need for these individuals to engage in services enables this growing population to improve their quality of life. It is difficult to compile an accurate count of the homeless adults in North Carolina as there are numerous homeless camps around the State and the camp locations are frequently changing. Adult PATH outreach numbers actually increased in SFY 2006-07 due to PATH programs being fully staffed, training that was done, and technical assistance provided by

In terms of increasing housing options, the Department of Health and Human Services and the Division have provided technical assistance to local programs to secure Shelter Plus Care housing opportunities for Division consumers. As a result of these efforts, in December 2005, HUD announced twenty-one (21) North Carolina communities would receive $13,139,239 in Continuum of Care Funding that will provide emergency, transitional, and permanent supportive housing for persons with mental illness. Last year, the HUD Continuum of Care funding for North Carolina was $15.5 million dollars that went to fifteen Continuum of Care programs covering 98 counties in our State.

The Division of Mental Health is an active member of both the Governor's Housing Coordination and Policy Council and the North Carolina Interagency Council for Coordinating Homeless Programs. This Interagency Council is appointed by the Governor and includes representatives of State agencies, nonprofit housing providers, local government, the NC legislature and formerly homeless persons and is charged with combating the problem of homelessness by coordinating program development and the delivery of essential services.

The Council sponsored its ninth Annual Conference on Homelessness entitled "Walking Home Together: Steps to a Practical Approach" on April 10-11, 2007 at the Jane S. McKimmon Center in Raleigh. The Conference was attended by over 500 persons from across the state representing non-profit homeless service providers, government agencies, the faith community, people who were or had been homeless and community volunteers. The Conference featured workshops on such topics as supportive housing development, education for homeless children and youth, housing funding sources, case management and outreach services, services for the mentally ill and/or substance abusing homeless person and the civil rights of individuals who are homeless.

North Carolina continues to work across Divisions toward the goals that were established during our participation in the Policy Academy to End Chronic Homelessness (from January 2003 in Atlanta):

Goal I - Build State Level Commitment and Leadership
Goal II - North Carolina Will Pursue Aggressive Prevention Strategies

Goal III - Develop More Permanent Supportive Housing

Adult- Rural Area Services, Including Transformation Activities Related to Criterion IV

Providing services to people who live in rural or urban communities of their choice is the primary focus of the redesigned mental health system. For tracking people in rural areas, data is gathered based on the numbers of adults served in area programs by county and categorized into rural areas compared to general population rates. The state performance indicators for *Services for Persons in Rural Areas* and *Services for Persons in Urban Areas* both reflect the numbers of adults per 10,000 population that are being served in Local Management Entity catchment areas by county and categorized into either rural or urban areas compared to general population rates. To better accommodate people living in rural areas, providers may offer satellite clinics, flexible hours, extended hours for people who work, etc.

North Carolina is the sixth largest state based on population, which was 8,049,313 according to USA Statistics in Brief – Census 2000 Resident Population of States. This is an increase of 21.4 % or 1,420,676 people since the 1990 census making the state the sixth fastest growing in population.

Population estimates for July 2003 indicated that 77% of the population lived in or near urban areas (i.e. in a catchment area containing county that is classified as a Metropolitan Statistical Area). Much of the population growth since the 1990 census was in urban areas. However, the 2000 census data indicate that 23% of the population continues to reside in rural areas and in small towns and cities throughout the state.

North Carolina is comprised of a total area of 52,669 square miles including 3,826 square miles of inland water; 20,043,300 acres of forested land; and 3,375 miles of shoreline on the Atlantic Ocean. People in rural areas often live at some distance from service sites and lack of transportation is generally acknowledged as being a problem. To make services more accessible, providers may deliver services in rural counties using a variety of methods including satellite clinics, alternate clinic scheduling hours and days, rotation of clinical staff to off site clinics, local coordinated transportation services, flexible appointment scheduling, co-location of services with other human service programs, and transportation by staff.

Criterion 5. Management Systems: Resources for Providers, Including Transformation Activities Related to Criterion V

Activities related to this criterion have included and will continue to include accessing Mental Health Block Grant funding and Mental Health Trust Fund monies to increase community capacity, and other key activities that support this criterion include training and manpower development.

Financial Resources

Role of Mental Health Block Grant

North Carolina's Mental Health Block Grant final award for 10-1-05 through 9-30-07 was $10,474,912 and the award for 10-1-2006 through 9-30-08 is $10,916,330. Because North Carolina's fiscal year is from July to June, the budgeted MHBG funds include remaining funds from FFY 07 and part of the FFY 08. The amount of Mental Health Block grant funds budgeted for North Carolina's fiscal year (SFY 07-08) is $11,176,923. Of that amount, $5,654,932 has been budgeted for provision of community-based services for adults with serious mental illness and $3,921,991 has been budgeted for provision of community-based services for children with serious emotional disturbances; $1,500,000 for the Comprehensive Treatment Services Program for children and State-level administrative expense are budgeted at $100,000.

The majority of the Mental Health Block Grant funds for adults with serious mental illness will continue to be allocated to Local Management Entities to provide continued funding to contract for community based services that are reimbursed on a unit cost basis through the Division's Integrated Payment and Reporting system In additions, some examples of specialized service approaches that are partially supported by Mental Health Block Grant funds include Mental Health/Adult Geriatric Specialty Teams, specialized staff to work with consumers who are deaf, and housing specialists.

MHBG funds will also continue to be used to contract with organizations such as the North Carolina Mental Health Consumers' Organization and the North Carolina National Alliance on Mental Illness chapter to provide services such as support groups and educational programs such as "Family to Family." In addition funding from the MHBG will also continue to be used to support contracts focused on activities such as consumer outcome measurement, training for clinicians, and credentialing of peer support specialists.

NC Mental Health Trust Fund to Increase Community Capacity

The North Carolina General Assembly established a Mental Health Trust Fund in SFY 01-02. These funds have been used each year to provide one time start-up funding to increase community service capacity. For example, in SFY 06-07, the Division issued requests for applications from LMEs in collaboration with contracted service providers to fund projects designed to assist with one-time non-recurring needs in SFY 06-07 and 07-08 related to the provision of community services to consumers. Initiatives that were funded included increasing local capacity to address the service needs of adults with mental illness, children with substance abuse, and adults with substance abuse.

State Mental Health Trust Funds were also used to fund a three year pilot project to address homelessness for people with disabilities by partnering staff devoted to the development of housing options with Assertive Community Treatment Teams and Community Support Teams. The combination of housing emphasis with treatment has been proven to be effective in other areas of the country.

Financial Statements & Description of Other Funding Sources

The local public mental health system supports the provision of services by a combination of Federal, State, and County funds and reimbursement from Medicaid and other insurance.

Overview of DMHDDSAS Total System Funding 2006-2007

Community mental health funds specifically for community based child and adult mental health services total $670,308,283. Of that amount, $110,808,324 is DMH allocated State appropriations; $13,929,598 is DMH allocated Federal funds including the MHBG; $315,079,424 are Medicaid payments to LMEs; and $230,490,937 are Medicaid payments to direct enrolled providers.

Total funding for all mental health, developmental disability, and substance abuse services, non-disability specific service, and management and administration is $2,678,574,821 of which $2,039,809,090 (76.15%) is for community based services; $605,256,241 (22.56%) is for state operated institutions; and $34,509,490 (1.29%) is for central office administration and management. (Note that this overview does not include County funds that are budgeted locally for services since those funds are not allocated by the Division of MH/DD/SAS.)

Information and Tracking Resources

Integrated Payment and Reporting System

The Division initiated implementation of the Integrated Payment and Reporting System (IPRS) in 2002. This system replaced the outdated Pioneer system and four other program specific billing systems. The IPRS is designed to be a HIPAA compliant, multi-payer system integrated with the state's Medicaid payment system, enabling providers of services the ability to send one bill to the state for payment of state or federal monies. This system was pilot tested in the Spring of 2001 and has been in production status since the Fall of 2003.

Data Infrastructure

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services have successfully implemented the major goals of the Data Infrastructure Grants that have been awarded to the Department (DHHS). In the fall of 1998 the Division began general system design for a modern server based Client Data Warehouse (CDW). The CDW utilizes a secure FTP to process, clean and store the Division's clinical, demographic, outcome, satisfaction, eligibility and service/claims data. The data standards found in the FN10 document (Data Standards for Mental Health Decision Support Systems) served as the reference point for the CDW.

In 2001 the Division entered into a partnership with other Department of Health and Human Services (DHHS) agencies to participate in a departmental level decision support client data warehouse (DSIS). Data from the Division's Client Data Warehouse is being selectively migrated to the DSIS. The advantages and objectives to participating in the DSIS are outlined below:

- Continue to provide DMH/DD/SAS, Substance Abuse Mental Health Services Administration and other stakeholders with client and service information needed for accountability, management, planning and evaluation.

- Consistency with NC Department of Health and Human Services (DHHS) architecture, enterprise level solutions, and warehouse standards. This will make the current support and future evolutions of the warehouse sustainable.
- Health Insurance Portability Accessibility Act (HIPAA) compliant web based access to all stakeholders.
- Continue to partner with DHHS agencies in order to leverage State and Federal dollars that have already been invested in the development of other systems.
- Involve new technologies to ensure efficiency and security of data collection and cost-effective usage.
- Data collection and storage will be efficient and extracted from production systems whenever possible. The integrity of the data will be monitored and will be guided by current regulations for HIPAA compliance.
- Continued participation in the Data Infrastructure Grant conference calls and annual meetings.

Staffing and Training Resources

Workforce Development Plan

North Carolina has developed a strategic workforce development plan. The document describes the initial and multi-year goals and strategies for implementing a statewide system of planning and responding to education and training needs in North Carolina's public mental health, developmental disabilities and substance abuse system reform. The Statewide framework for workforce development will include the following two elements:

(1) A State system for workforce development that will support long-term policy and planning to engage a strategic and coordinated system for workforce development; and

(2) Use of technology transfer for initial and continued forums for learning communities across the state. This will include "webinars," web based, teleconferencing, telemedicine for clinical consultation and supervision as well as on-site mentoring to sustain quality and capacity of providers.

In addition to these on-going efforts that are being made, one of the current projects of the North Carolina Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services is workforce development.

Description of Staffing:

Direct service provision is carried out by staff from a variety of disciplines such as psychiatrists, psychiatric nurses, clinical social workers, psychologists, licensed professional counselors and certified clinical addiction specialists. In addition some service is delivered by paraprofessionals who are supervised by qualified professionals. Data are not available about the number of staff employed by each of the many provider agencies that have contracts with the local management entities to provide mental health services. However, the State office does receive information about the types of professionals that are in short supply locally. Those most frequently mentioned include nurses and psychiatrists.

Training for Mental Health Service Providers and Local Management Entities

The Division was a sponsor and a cosponsor of training through contracts with the North Carolina Council for Community Program's Local Management Entity Academy and

Leadership Forums, through the North Carolina Area Health Education System (AHEC) and through colleges and universities. An annual statewide case management conference was held in November 2006; more than 1100 people attended. The annual consumer empowerment conference held in the fall of 2006 accommodated approximately 300 people.

Mental Health Block Grant funding is used to contract with North Carolina National Alliance on Mental Illness (NAMI/NC) and will continue to provide the Young Family Network educational events, especially with young families, physicians and school personnel.

At present, the N.C. Council of Community Programs, the Behavioral Healthcare Resource Program (BHRP) of the UNC-CH School of Social Work and the UNC-CH Developmental Disabilities Training Institute (DDTI) provide division endorsed training. The division also launched a project to prepare experienced workers to provide training on the division's behalf.

Training for Providers of Emergency Health Services

As is the case with training about mental health services, the eleven Area Health Education Centers (AHECs) also work closely with health professionals about a wide range of health conditions, including emergency health services that may be used by consumers who have medical and mental health problems. In addition, Local Management Entities provide consultation, technical assistance and in service training for local emergency room staff and primary care physicians and other medical personnel about assessing and assisting patients who have serious emotional disturbance or acute mental illness.

Provider training on delivery of new services that incorporate first responder as a required function has occurred during this state fiscal year. It is anticipated that this training will continue and engage a cross-section of community partners as the screening, triage, and referral function is standardized.

In addition, this SFY through block grant funds, the Mental Health Association in NC, Inc. has provided targeted training with law enforcement, sheriffs' offices, public safety, fire and other emergency first responders. The training has focused on eliminating barriers, offering techniques, signs and cue reading for these service providers to become more sensitive and aware of opportunities to divert or prevent escalation of a potentially challenging situation. Communities who have participated in the evidenced based practice of Crisis Intervention Teams or CIT, have also engaged health care providers and first responders at large in the community in similar training.

In the coming year, we will explore training that can be offered to staff and instructors as well as training that can be offered as community outreach for continuing education through the community colleges. It is anticipated that consumers, families and youth will be engaged in developing and offering this trainings.

Evidence Based Practice Training

In terms of other types of training, many sessions have been done which included evidence-based practice trainings, as well as trainings pertaining to best practices and

person-centered planning. The Southern Regional Area Health Education Center in Fayetteville is the home of the North Carolina Evidence Based Practice Center which does the training on the following Evidence Based Practice Toolkits: Assertive Community Treatment Teams, Supported Employment, Family Psycho-Education, Wellness Management and Recovery, and Integrated Dual Disorders Treatment. Many competency based training opportunities have been provided which focus on evidence-based practices, as well as trainings pertaining to best practices and person-centered planning. Evidence Based Practices are a major part of reforming mental health services, both on a state and national level, and appropriate training is critical to help achieve this goal.

North Carolina

Adult - Purpose State FY BG Expended - Recipients - Activities Description

Adult - A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

Adult Report Summary of Block Grant Monies Expended
(Grant Recipients and Activities)

North Carolina's total Mental Health Block Grant expenditures (revenue drawn) for SFY 2006-07 on the year end authorized report were $10,736,148.81, which includes both direct and non-direct service activities. This total does not include Medicaid or local funds that are used in funding services. Non-direct service activity reflects contracts, technical assistance activities, Mental Health Planning Council activities, and administration. Non-direct service activity expenditures for the SFY 2007 reporting year were $1,418,493. The majority of the Mental Health Block Grant funds for adults with serious mental illness will continue to be allocated to Local Management Entities to provide continued funding to contract for a variety of services that are needed in local communities, especially for those people who aren't Medicaid recipients and who have little or no income. At the end of this section on Mental Health Block Grant expenditures, there is a table detailing final continuation allocations of Block Grant funds allocated to each of the 30 Local Management Entities in the State. Mental Health Block Grant funds will also continue to be used to contract with various organizations, as described in greater detail below.

North Carolina's Mental Health Block Grant final award for FFY 2007 was $10,916,330. North Carolina received an increase of $441,418 or 4.2% in the Community Mental Health Services Block Grant Plan final allocation amount for 06-07; however, because it was received so late in the fiscal year, the increase was reflected in SFY 07-08 (the actual allocation for SFY 06 was $10,474,912) State-level administrative expenses will be no more than the allowed 5% of any given grant award.

The Division's Integrated Payment and Reporting System or IPRS limits the use of Mental Health Block Grant funds to specific target populations (adults with severe and persistent mental illness and adults with serious mental illness). The IPRS is designed to be a Health Insurance Portability and Accountability Act or HIPAA-compliant, multi-payer system integrated with the state's Medicaid payment system, enabling providers of services the ability to send one bill to the state for payment of state or federal monies. This payment system ensures that Mental Health Block Grant funds are not used to provide inpatient treatment.

Examples of the types of services that have been supported by Block Grant funds include: psychosocial rehabilitation, evaluations, medication management, supported employment, and other services in the North Carolina covered service array. Block Grant funds have also been used to continue funding housing development specialists and jail diversion projects, such as the Crisis Intervention Team in Wake County (law enforcement staff have received specialized training in dealing with adults who have serious mental illness and are in crisis, thus, preventing inappropriate incarceration). Mental Health Block Grant funds were also used to support the new services that went into effect in mid March 2006, such as Community Support, Community Support Team, Intensive In-Home Services, Mobile Crisis Management, Assertive Community Treatment Team, and Diagnostic/Assessment through the IPRS for adults with serious mental illness.

There are 20 Mental Health/ Adult Geriatric Specialty Teams around the State which are specialized mental health teams that provide community based services. Community Mental Health Block Grant funds are used to support these Teams, whose focus is on training the caregivers who work with older individuals that are at risk for psychiatric hospitalization and try to keep them in the community. Starting in January, 2007, another team member was added to address the needs of younger people with mental illness residing in long term care facilities. Team members do not provide direct service but typically provide technical assistance and education to Long Term Care providers and home-based caregivers. They can also do trainings at Senior Citizen Centers as well.

Division contracts which utilize Block Grant funds (and which will be discussed more fully below) include NAMI (National Alliance on Mental Illness) Child and NAMI Adult, the North Carolina Mental Health Consumers Organization (NCMHCO), the Mental Health Association, Eastern Carolina University (this contract with Eastern Carolina supports a social work degree program with an emphasis on preparing students to work with those who are deaf or hard of hearing and who have mental illness), University of North Carolina at Chapel Hill School of Social Work Behavioral Healthcare Resource Program, University of North Carolina Dept. of Psychiatry (this contract provides for students to receive stipends who want to complete internships with the Division), and the Duke Child and Family Health Center.

The NCMHCO Executive Director provided a contract report about this organization earlier at one of the Mental Health Planning and Advisory Council meetings as they are a recipient of Mental Health Block Grant funding. She discussed other activities/events as follows that utilize Block Grant monies: NCMHCO also offers Wellness Recovery Action Plan (WRAP) Training sessions in each region of NC. This year, NCMHCO conducted an After-Care WRAP Program to ensure consumers are benefiting from WRAP and how to focus on the individual WRAP plan. They also offer a Leadership Training Academy in Raleigh, NC each December. The Leadership Academy promotes consumer involvement in Leadership and Civic Participation throughout the year. It is a self help program that teaches organizational skills and encourages individuals to become self advocates and educates the community on issues concerning behavioral health sciences.

The Mental Health Association (MHA) in North Carolina was first organized in 1914 and chartered in 1939. They are the state's largest private, non-profit mental health organization addressing advocacy, education and service. Their mission is to promote mental health, prevent mental disorders, and eliminate discrimination against people with mental disorders. These goals are accomplished through community advocacy, education and service. MHA affiliates consist of both staff and volunteers and currently serve over 50 North Carolina counties.

The contract with the North Carolina Chapter of the National Alliance on Mental Illness helps to provide services such as support groups and educational programs (i.e., "Family to Family," etc.). The mission of NAMI North Carolina is to improve the quality of life

for individuals and their families living with the debilitating effects of severe and persistent mental illness. They work to protect the dignity of people living with brain disorders through advocacy, education, and support. Membership in the affiliates in North Carolina consists primarily of family members of people who have mental illness, and also includes consumers, friends, and professionals. Affiliates typically have monthly support meetings and/or educational and business meetings. When mental illness strikes, it is usually surrounded by confusion and isolation. Support groups can provide an opportunity to talk with other people who have "been there" and who understand what you are facing. General meetings have speakers on issues important to members.

North Carolina has adopted several goals from the 2003 President's New Freedom Commission on Mental Health and one of them focuses on improving and expanding the workforce. One means of accomplishing this is to train providers in service delivery that helps people reach their goals on their journey to recovery and self determination. The Behavioral Healthcare Resource Program (BHRP) at the University of North Carolina in Chapel Hill (through a contract with the Division which utilizes Block Grant funding), assists with training such as this, staff development, technical assistance and leadership consultation. This program is part of the Jordan Institute for Families in the UNC School of Social Work and acts as a bridge between a research–oriented academic setting and community professionals.

Information about the Mental Health Block Grant funds expended by Local Management Entities for services for adults with serious mental illness is provided in the table on a following page.

Since this section of the Implementation Report addresses monies expended during SFY 2006-07, it seemed appropriate to include an update on North Carolina's Maintenance of Effort/State Expenditures for Mental Health Services Report. States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory Maintenance of Effort (MOE) requirements.** MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant. Set Aside for Children is also included below as well.

MOE information reported by:
State FY ___X_____ **Federal FY_____**

State Expenditures for Mental Health Services

Actual FY 2005	**Actual FY 2006**	**Actual FY 2007**
$251,939,348	$274,924,661	$432,482,015

****Section 1915(b(1) of the PHS Act**

Set Aside for Children
State Expenditures for MH Services:

Calculated FY 1994:	Actual FY 2006:	Actual FY 2007:
$46,773,250	$133,332,002	$241,933,373

SFY 06-07 Final Expenditures of Mental Health Block Grant Funds

Local Management Entities	Adult
Alamance-Caswell-Rockingham Mental Health DD/SAA	163,154
Albemarle Mental Health Center DD/SAS	200,205
Catawba County MH Services	139,906
CenterPoint Human Services	159,648
Crossroad Behavioral Healthcare	244,333
Cumberland County Mental Health Center	105,444
The Durham Center	80,000
Eastpointe	204,760
Edgecombe-Nash MH/DD/SAS	52,595
Five County	365,985
Foothills Mental Health DD/SAP	240,379
Guilford Center for BH/DS	241,185
Johnston County Area Mental Health MR/SAA	37,588
Mecklenburg Mental Health and Community Service Department	274,691
Neuse Center for Mental Health DD/SAS	89,541
New River Behavioral HealthCare Services	238,091
Onslow County Behavioral HealthCare Services	120,678
Orange-Person-Chatham (OPC) Mental Health DD/SAA	80,920
Pathways Mental Health DD/SA	202,151
Piedmont Area Mental Health MR/SAS	346,703
Pitt County Developmental Disabilibities & Substance Abuse Services	47,387
Roanoke-Chowan Human Services Center	75,227
Sandhills Center for MH/DD/SAS	128,970
Smoky Mountain Center for Mental Health DD/SAS	146,896
Southeastern Center for Mental Health/DD/SAS	256,658
Southeastern Regional for Mental Health DD/SAS	210,518
Tideland Mental Health Center	59,323
Wake County Human Services	148,079
Western Highlands	1,920,625
Wilson-Greene Area Mental Health MR/SAS	90,420
TOTAL	6,672,060

The Integrated Payment and Reporting System (IPRS) ensures that state and federal funds are used to reimburse the local programs for community based services to priority populations**.**

North Carolina

Child - Summary of Areas Previously Identified by State as Needing Improvement

Child - Report Summary of areas which the State identified in the prior FY's approved Plan as needing improvement

NC Mental Health Planning and Advisory Council
NC Division of MHDDSAS
NC DHHS
Implementation Report for SFY 06-07

NC Mental Health Block Grant Implementation Report - Child

1. Child - Summary of Areas Previously Identified by North Carolina as Needing Attention

1.a. Introduction – Coordinated NC State Plan and ADM Mental Health Block Grant Plan Priorities

As advisors to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (MHDDSAS) regarding the federal Block Grant, members of the North Carolina Mental Health Planning and Advisory Council (NCMHPAC) have been committed to fulfill this role during the course of their work during this past year. In addition, the Council members recognize their role as constituents who are engaged in more than sixty different leadership roles and/or collaborative partnerships in their community, state and nationally. Council members bring and exchange information at the Council table as well as among these numerous diverse spheres of influence. These are outlined in the recently updated Table 1 in the Appendix B.

The Council has made a concerted effort to link the Division of MHDDSAS State Strategic Plan and the federal Block Grant Plan this past year. North Carolina Mental Health Planning and Advisory Council members embrace the Division's mission, guiding principles as outlined below and believe that the Division's transformation efforts align with targets of Council's interest and focus for which activities have been implemented and will continue through the block grant funding.

State's Vision for the Future

Division of MHDDSAS State Plan Mission

North Carolina will provide people with, or at risk of, mental illness, developmental disabilities and substance abuse problems and their families the necessary prevention, intervention, treatment services and supports they need to live successfully in communities of their choice.

Division of MHDDSAS State Plan Guiding Principles

- Participant driven
- Community based
- Prevention focused
- Recovery outcome oriented
- Reflect best treatment/support practices

- Cost effective

Division of MHDDSAS State Strategic Plan 2007-2010 – The Vision for a Transformed System

- Public and social policy toward people with disabilities will be respectful, fair and recognize the need to assist all that need help.
- Services for persons with mental illness, developmental disabilities and substance abuse problems will be cost effective, will optimize available resources – including natural and community supports – and will be adequately funded by private and public payers.
- System elements will be seamless: consumers, families, policymakers, advocates and qualified providers will unite in a common approach that emphasizes support, education/training, rehabilitation and recovery.
- All organizations and individuals that serve people with mental health, developmental disabilities and/or substance abuse problems will work together to enable consumers to live successfully in their communities.

Consumers will have:

- Meaningful input into the design and planning of the service system.
- Information about services, how to access them and how to voice complaints.
- Easy, immediate access to appropriate services.
- Educational, employment or vocational experiences that encourage individual growth, personal responsibility and enjoyment of life.
- Safe and humane living conditions in communities of their choice.
- Reduced involvement with the justice system.
- Services that prevent and resolve crises.
- Opportunities to participate in community life, to pursue relationship with others and to make choices that enhance their productivity, well being and quality of life.
- Satisfaction with the quality and quantity of services.
- Access to an orderly, fair and timely system of arbitration and resolution.

Planning Council Charge, Role, and Activities

North Carolina Mental Health Planning Council: Activities and Accomplishments

Mental health planning and advisory councils exist in every State and U.S. Territory because of the passage of federal law 99-660 in 1986, continuing through Public Law 101-639 and Public Law 102-321 in 1992. The federal law states that the planning council is expected to do the following:

1. To review the Mental Health Block Grant Plan and to make recommendations.
2. To serve as an advocate for adults with a serious mental illness, children with a serious emotional disturbance, and other individuals with mental illnesses.
3. To monitor, review and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

Individuals shall be appointed by the Secretary of the Department of Health and Human Services to fill membership positions for 3 year terms. The North Carolina Mental Health Planning Council is made up of 28 members, ten of whom represent adult consumers with mental illness or family members of children with serious emotional disturbance, eight of whom represent mental health advocacy organizations, eight of whom are state employees and two of whom are providers of mental health services. The Council meets six times per year in Raleigh, the capital of North Carolina. Below is a listing of Planning Council events, activities, and accomplishments that have occurred within the past fiscal year.

July—September, 2006

- As a means to allow Planning Council members an opportunity to review information and data pertinent to their respective advocacy-orientation (for inclusion in the Block Grant Plan), there were separate committee meetings held in July; the Adult Committee met on July 14, 2006 and the Child/Family Committee met on July 21, 2006. Quality Management Team staff members were present at both committee meetings to inform Council members and respond to questions. For more details about the July Committee meetings, please follow this link to the Planning Council website: http://www.ncdhhs.gov/mhddsas/mhplanning/index.htm
- Division liaison staff discussed the Mental Health Block Grant Plan process and the timeline for the Plan and the Implementation Report (which assesses the progress made in the previous year's Plan).
- Council members reviewed the completed draft of the Plan and feedback was received. The review included a listing of Planning Council activities for the past year, as well as a review of the goals, objectives, updates, measures and data for indicators found in the Mental Health Block Grant Plan (that was due in 09/06 for FFY 07 and subsequent report due in 12/06 for FFY 06). Council discussion focused on setting priorities, and feedback regarding achievements and challenges of transformation to be included in this year's Plan. In the August, 2006 meeting, Council members voted on the priorities on which they wanted to focus during the upcoming meetings in FFY 2006-07.
- Council members requested the addition of Evidence-Based Practice Indicators in both the child and adult sections and this request was implemented via adding a data table in the adult section tracking consumers who receive Assertive Community Treatment (ACT) and by the addition of a data table in the child section which tracks children in Therapeutic Foster Care.
- A representative from Prevention and Early Intervention Team at the Division provided an update on the status of the System of Care (SOC) Coordinator positions; there will be one Coordinator per each of the 30 Local Management Entities or LMEs through the use of State recurring funds in order to expand SOC statewide.
- Chair asked the Council to review the draft transmittal letter that will accompany the Plan when it is submitted. Revisions were made at members' request and there was agreement that the letter would be sent as revised based on the discussion with the Chair's signature.

October—December, 2006

- Council members reviewed priorities they had chosen in the last meeting (August), with the framing of those five priorities into the agendas for the last three Council meetings in SFY 2006-07 (January, March, and May, 2007).
- To move these priorities from the "idea" stage to planned agenda items, Council members utilized the format for implementation planning from training done by staff from the National Association of Mental Health Planning and Advisory Councils (NAMHPAC) in the spring of 2006, referred to as SMART Goals; SMART is an acronym which stands for S-Smart, M-Measurable, A-Agreed upon, R-Realistic, and T-Time-limited. This process involves identifying the SMART Goals, identifying any barriers or resources to achieving the goals, action steps to be taken, the person(s) responsible for working on the SMART Goals, and the timeframes for accomplishment. Council members identified questions for each of the meetings in which priorities would be discussed, such as resource information (what do we know, what do we need to know), resource contacts (who can share information about the particular area of priority--council member, staff member, outside speaker, etc.), and timeframes.
- Council members felt strongly that increasing service capacity, collaboration, and consumer and family involvement transcend all the other priorities and will be "embedded" within those ensuing presentations and Council discussions. Out of the October meeting came a table format document outlining the areas considered for each meeting dealing with priorities. As these January, March, and May meetings are held with discussion and information sharing, the resulting documentation of such will serve as resource information to inform Council dialogue and help shape recommendations regarding indicators or measures for the FFY 2007-08 MHBG Plan.
- Members reviewed and provided input and feedback for the Mental Health Block Grant Implementation Report (to be submitted 12/01/06) and considered the following as issues to be covered in future meetings: homeless population and how increasingly, veterans are falling into this group; transition services for children who age out of the child systems in DMH/DD/SAS, DSS (Division of Social Services), and DPI (Dept. of Public Instruction); linking crisis services with the reduction of consumer involvement in the justice system; and training (for consumers, family members, and providers); and the aging population with MI.
- A contract report was provided to members by the North Carolina Mental Health Consumers Organization (NCMHCO) Executive Director as they are one recipient of Mental Health Block Grant funding (NCMHCO activities: Wellness Recovery Action Plan (WRAP) Training in each region of the State, a statewide conference with awards banquet for 200 consumers with the theme of: *Discover Your Strengths—Achieve New Heights*.
- Council Chair was the Recipient of the 2007 North Carolina Mental Health Consumers Organization's Staff Award for Leadership, Advocacy, and Excellence and also serves as a SAMHSA (Substance Abuse and Mental Health Services Administration)/CMHS PAIMI (Center for Mental Health Services Protection and Advocacy for Individuals with Mental Illness) Peer Reviewer, NIMH (National

Institute of Mental Health) Public Participant Reviewer and is a member of the Division's Practice Improvement Collaborative.

- October and November meetings focused on gathering input from Council members about achievements/accomplishments, and challenges/concerns both from the past year and priorities for the coming year (please refer to the Achievements, Challenges/Needs, and Priorities Section immediately following this quarterly list of Council highlights)
- The Housing Finance Agency Council representative indicated that there was new Money available for supported housing; new apartment units have opened in Raleigh for persons with mental illness.
- The Division of Aging and Adult Services representative informed the Council that the Older Americans Act had been reauthorized; funds for grants will be appropriated to states for using Evidence-Based Practices in the treatment of older Americans.
- Members were able to have an open discussion with Division Director Mike Moseley during the November meeting with opportunities for frank questions and answers.
- Council members agreed and the motion was made and carried that the transmittal letter to accompany the Implementation Report when it is submitted will include recommendations/highlights as just discussed in the committees. The letter will go to the Executive Committee for final approval and then forwarding to Chair for signature.
- Members were given two handouts at the November meeting, one of which was the Council Meeting Schedule for 2007 and the other handout serves as a planning outline for SFY 2006-07 Council meetings and discussion of Block Grant criterion priorities as a basis for informing the Council. This outline covers the three remaining Council meetings in this fiscal year, with Block Grant Plan criteria indicated as well as Council priorities around each particular criterion.
- One Council member has been asked by her home county to serve on the committee which conducts the homeless count in January 2007; since homelessness is a priority of the Council, she will report back to the Council once this task has been completed.
- Linda Swann from NAMI (National Alliance on Mental Illness) delivered a contract report and discussed those contracts supported by Mental Health Block Grant funds, such as the Family to Family contract and the Young Families contract. Through Block Grant funds, she can also pay for consumers to help her present and she also utilizes the funds to help create and disseminate brochures to educate the community.

January—March, 2007

- In January, the meeting focused on Block Grant Criterion IV, Targeted Services to Homeless Populations. Council interests under this criterion include decreasing barriers to services, specifically in housing and transitions (e.g., as in transition from child to adult services or across systems). Panelists who informed the Council included Joan McAllister (Division of Social Services) who spoke about transition needs for children and youth, especially those who have been in foster care

placements; Debra McHenry (Department of Public Instruction) spoke about the McKinney-Vento Homeless Education Act and discussed definitions and statistics related to that law. Debbie Webster (Division of Mental Health/Developmental Disabilities/Substance Abuse Services) spoke about the Projects for Assistance in Transition from Homelessness (PATH) programs in North Carolina; Glenn Silver, also from DMH/DD/SAS spoke about his role as Housing Coordinator for the Division and the housing initiatives and grants that he is involved with; and Mary Reca Todd from the North Carolina Housing Finance Agency spoke about the need for supportive housing in our State and some of the recent housing achievements, in terms of funding and actual housing units.

- During January's meeting, the Vice-Chair began serving as Council Chair; nominations were taken for Vice-Chair and the new Vice-Chair was elected by the Council; the Child/Family Committee approved a new Committee Chair, along with a back-up.
- Shealy Thompson, Team Leader of the Quality Management Team, spoke to the Council about the recent change in summarizing the input from the North Carolina Consumer Satisfaction Survey. The major change in the survey methodology is what constitutes a positive response, based on how the consumer/family member responds to the survey questions. This change was the result of an effort to better align North Carolina's data information and implementation reporting process with federal and state protocols.
- In keeping with the Council priorities and their review of Block Grant Criterion V. (Management Systems: increase consumer and family involvement and workforce development), Ann Remington, Consumer Empowerment Team Leader, from the Advocacy and Customer Service Section presented on consumer and family member involvement with State and Local Consumer and Family Advisory Committees or CFACs.

  In terms of workforce development, information was shared with the Council regarding the Univ. of North Carolina at Chapel Hill School of Social Work's Behavioral Healthcare Resource Program (BHRP). The BHRP is designed to provide clinical consultation, technical assistance, and trainings designed for professionals working in the public mental health and substance abuse programs. Following are comments and considerations from Council members regarding workforce development:

  -look for ways to increase recovery based systems and principles in training
  -look for ways to inplement and train on the recovery model (consumer to consumer based training, not too clinical)
  -adjust qualifications of trainers (e.g., endorsed trainers have a Master's level education): increase number of trainings in which consumers/families are trainers, increase number of trainings and educational opportunities in which the design, writing, training, and evaluation are done by/with consumers/families as full partners
  -engage consumers/families in partners in cross-agency training as participants and trainers

-establish peer specialist service definition for child and family Mental Health services/supports and use more broadly for adult services/supports (e.g., expanded definition for child and family could be used in schools and in coordinated school training; working example in place and being implemented in SFY07, also implementation of a blended child and family team curriculum (developed, tested, and trained by families of children with serious emotional disturbance), and blended funds from all child-serving agencies; establish good standards of practice and improve quality of services/supports provided
-encourage Local Management Entities to use funds through non-UCR (Unit Cost Reimbursement) to offer elective trainings developed and provided by consumers/ families as partners
-include Department of Corrections staff to help support treatment best practice and coordinate community re-entry
-update and maintain a training calendar to reach a broad audience

- A Council member participated in the homeless count in Greensboro
- Another Council member will be doing WRAP (Wellness Recovery Action Plan) Training in groups composed of ladies involved in the Work First Program, while another is doing WRAP training for children who reside in Level IV Group Homes.
- Another member has been working with the school system and juvenile justice system.
- One Council member discussed updates from the Division of Prisons and how they will be working with Division of Veteran Affairs on behalf of veterans before they are released from prison to initiate services.
- One Council member is now the Legislative Liaison for the NC Dept. of Juvenile Justice and Delinquency Prevention and will be able to do more advocacy.
- While in committee, members discussed training, education and advocacy-related efforts in which they are involved during the March meeting. This information will be used to update the document, *Consumer and Family Involvement and Advocacy Opportunities in North Carolina*, and further inform Council members about their fellow co-members' stakeholder activities.

April—June, 2007

- At the May meeting, the Council representative from the Division of Aging and Adult Services provided a report on the SAMHSA-sponsored workshop she attended entitled, *Making the Mental Health System Work for Older Adults with Mental Illness*.
- Presentations in the May meeting focused on MHBG Criterion II. Data Epidemiology and Criterion III. Children's Services. Antonio Coor from the Division's Justice Systems Innovations Team, presented on reducing mental health consumer involvement in the juvenile justice system via his overview of the MAJORS (Managing Access for Juvenile Offender Resources and Services) Program. Bob Kurtz, Ph.D., also from the Justice Systems Innovations Team, presented on reducing mental health consumer involvement in the Justice System (e.g., jail diversion), and brought Chris Wassmuth (Crisis Intervention Team Coordinator for Wake County) as his guest.
- Adult Committee members provided feedback during the May Committee meeting

that will be submitted to the Quality Management Team regarding their review of specific questions in NC-TOPPS (Treatment Outcomes and Program Performance System) that relate to justice system involvement by the consumer.

- Council Chair discussed the approval by the Division to provide the Council with $1000 to spend during the next SFY (July 1, 2007- June 30, 2008). This is non-service money and the Division needs to have final approval of projects/plans before funds are actually expended. Options discussed today included conferences, trainings, having staff come down from the National Association of Mental Health Planning and Advisory Councils and do training, developing a questionnaire for consumers/family members to respond to, or having focus groups around the state to get input and share Council information and educate people about the Council. The Chair will discuss this matter further with Bonnie Morell, Team Leader of the Best Practice Team in the Division, and then will update Council members.
- One Council member informed the Council about Coalition 2001's "Advocacy Rally Day" which will be held at the Legislative Building.
- Another member discussed the Medicaid Infrastructure Grant (MIG) that the Division of Vocational Rehabilitation holds, which has as one of its key elements, a Medicaid Buy-In component (people with disabilities could continue to work and "buy-in" to get their own Medicaid coverage). The request was made to the Council to write a letter supporting the application of a continuation grant if needed; Council members agreed by acclamation to write the letter via a drafting of such by the Executive Committee, if needed.
- Council members were asked to review the Division's new three year State Strategic Plan that is now posted on the Division website for public comment; the Council Chair asked members to send comments.
- Council Chair and Division staff attended the 2007 Joint National Conference on Mental Health Block Grant and National Conference on Mental Health Statistics.
- Members did hear proposals regarding possible recommendations from the Council to the Division of Mental Health/Developmental Disabilities/Substance Abuse Services about the use of the increased Block Grant funding received from the Substance Abuse and Mental Health Services Administration. Council Chair sent a letter to federal funders acknowledging Council's participation in this recommendation process.

Below is a list of comments, including the achievements, challenges, and priorities as provided by Council members in discussing transformation in general throughout the year, and in their review of the Community Mental Health Services Block Grant Plan. North Carolina Mental Health Planning and Advisory Council outlined the following Priority Areas of Focus during SFY 07 Plan year and will be addressed during the FFY 08 Plan year.

Achievements as Expressed by Planning Council Members:

- Training: Council members are involved in training, such as recovery training Wellness Recovery Action Plan (WRAP) training for youth in transition and their families, Peer Support training for families of children/youth, working with

community collaboratives, self-advocacy, CFACs, and Families and Teachers s Allies with school personnel, families and youth as well as new Family to Family training for families with younger children/youth through NAMI/NC (National Alliance on Mental Illness). In fact, NAMI's Young Family Network was chosen as a state pilot for this new family program.

- Progress has been made in community capacity; if Community Support is done correctly, it does provide a unique support; Community Support Specialists have filled a gap in the service delivery system.
- Therapeutic Foster Care has been a service in place for sometime, but now with coordinated licensure rule through DSS with the mental health service definition. In addition, a cross-agency 10 hour specialized training for Therapeutic Foster Parents has been designed in SFY07 and will be implemented in SFY 08.
- Many Local Management Entities have provider meetings on a monthly basis.
- Family Support services can help consumers in the process of systems navigation and can link them with community resources.
- "Pockets of Excellence" in implementation of EBPs and family centered practices are growing in NC amid the significant system changes occurring.
- The Division of MHDDSAS and the legislature have established benchmarks to track Evidence Based Practices and funding expenditures.
- The recent passage of the mental health Parity legislation by the Senate and House; this bill requires health insurers in the state to provide the same level of coverage for treatment of severe depression, schizophrenia or other mental illnesses as they do for physical illnesses.
- Local newspapers in many areas are now showing how the legislators voted; they are increasingly looking to consumers for input; articles are being written about local service providers to inform and educate the public.
- All Local Management Entities have crisis plans and are responsible for reporting status and implementation efforts to the Division on a quarterly basis that are then reported to the Legislative Oversight Committee (LOC).
- Effective 2/07 the Interagency Memorandum of Agreement (IMOA) was signed and went into effect between the Division of Vocational Rehabilitation Services and the Division of Mental Health/Developmental Disabilities/Substance Abuse Services; this IMOA focuses on employment goals (some mutual goals between the two divisions and other individual divisional goals); some components include discharge planning from state psychiatric hospitals and training.
- One Council member has introduced WRAP training with families and older youth in life transitions who had unmet needs and were dealing with loneliness and isolation.
- Council members, both child and adult committee members, voiced approval of the efforts going on around the State in terms of housing initiatives, such as the Housing 400 Initiative and support of the Key Program, which provides bridge funding or operating funds as a form of rental assistance. Council members had specific areas of interest and focus in housing options: housing for those in recovery, housing for survivors of domestic violence (either permanent or transitional – beyond emergency shelters), CASA programs for women and children (with on-going education/training/support for substance abuse issues and

parenting), and Oxford House programs for those in re-entry from the prison populations back into the community.

- Members supported Division efforts to have Peer Support positions in the PATH (Programs for Assistance in Transition from Homelessness) programs, including those for children/youth.
- Achievements identified regarding transformation efforts included the following**:**
  -- Implementation of Evidenced Based Practices (EBP); possible measures that could be used to track the increase in EBPs include the number of children receiving EBP services, the number of providers endorsed to provide EBPs, such as Multi Systemic Therapy and Therapeutic Foster Care; and the number of trainings provided to expand implementation of EBPs statewide;
  -- Increased opportunities for consumer/family involvement in Person Centered Plans through Child and Family Teams; possible measure sources for tracking this would be NCTOPPS (North Carolina Treatment Outcomes and Program Performance System) and Local Management Entity performance reports; and
  -- Decrease in stigma; possible measures sources for tracking this would be the Divisions of Public Health and Social Services and Department of Public Instruction, where common outcomes are shared and measured.

Challenges/Needs Identified by Planning Council Members:

- There is limited state funding for trainings; some trainings need statewide centralized integration, such as for the expansion of Child and Family teams for purposes of Person Centered Planning. Increased funding is needed if this training is "watered down," there is the likelihood of losing fidelity to the practice model and process.
- Consumer education is critical to reduce stigma. There is also a need for providers to have training/education about other local providers and what services they provide.
- Local Management Entities need objectives that match the State Strategic Plan; Local Management Entity accountability is tied to the contents of their local business plan.
- Gang activity is increasing in some parts of the state and this is another area that needs more attention by law enforcement.
- As a result of paid claim reviews, it seems that some providers need to better understand the services being provided—how the services should look when delivered correctly.
- Community capacity should be developed in other areas besides increasing local crisis services, such as expanding Therapeutic Foster Care, Intensive In home services and MST in communities where youth are in need, in re-entry or reunification plan is in place.
- Training is needed for Peer Support Specialists and getting the proper education about their role is critical. The certification training for Peer Support Specialists is intense in North Carolina; other co-workers need to know what skills and abilities the Peer Support. Youth and families need to be included in this to grow such effective supports.
- Increase collaborative relationship-building between agencies and programs, including building youth and family leadership.
- Build consistent consumer education/training and incentives for people to realize the value/benefit of the training.

- Improvement needs to be made in service delivery for adults with maternal depression or adults who are parenting for whom depression goes untreated and impacts the child's healthy growth and development.
- Disparity exists in funding across the three disability groups and in those accessing services and supports. The Division's cultural competence plan and workforce development plan has begun to address disparities observed.
- Local Management Entities need to have disaster plans in place and the disaster coordination plans need to be integrated for all disabilities.
- Service access for those consumers in jail is another area of need (considering quantity and quality of service availability).
- Consumers need help in navigating the system and accessing services.

For more details on the involvement of consumers and family members in advocacy type activities, please refer to the two page table in Appendix B of this Implementation Report, entitled, ***Summary of Existing Opportunities for Consumer and Family Involvement and Advocacy in North Carolina*** (updated June, 2006).

A list of the North Carolina Mental Health Planning and Advisory Council members can be found in the Adult section of this report.

Adult Committee: (priorities are not listed by order of importance)

- Priority #1 – **Education/Training**: To increase education/training for consumers and family members as well as for providers/direct care/support staff. (Criterion V. Management Systems)

- Priority #2 – **Evidence-Based Practices** (EBPs): To support the development of EBPs that focus on jail diversion, after care practices on a post incarceration basis, services to older adults with mental illness, and services that support Peer Specialists. (Criterion I. Community Based System, Criterion II. Data Epidemiology, and Criterion III. Children's Services)

- Priority #3 – **Housing**: To increase the number of safe, affordable housing options for people with mental illness. (Criterion IV. Rural and Homeless and Criterion I.. Community Based System)

- Priority #4 – **Recovery**: To increase systematic support for the concept of recovery across the whole service delivery system. (Criterion I. Community Based System and Criterion III. Children's Services)

Child and Family Committee: Priorities for the next year for the child and family committee recommendations to the Council and the Division of MHDDSAS are listed below in priority order.

- Priority #1 **– Sustain Transformation through implementation of the essential components of a System of Care (SOC) approach** To sustain and build systematic support for the essential components of SOC across the whole service delivery system. Especially in the implementation of child and family teams as a vehicle for

person centered planning that is culturally responsive, outcomes driven and is guided by family and youth centered practice. (Criterion V. Management System, Criterion I. Community Based System and Criterion III. Children's Services)

- Priority #2 – **Workforce Development:** To increase provider capacity and quality of care delivered. (Criterion V. Management System, Criterion I. Community Based System and Criterion III. Children's Services)

- Priority #3 – **Consumer, Family and Youth Involvement:** To increase and sustain consumer, family and youth involvement in workforce development at all levels, as developers, trainers, participants at the state, regional and community levels. In particular, helping families learn how to choose a provider and helping providers understanding informed consent and decision-making. (Criterion V. Management System, Criterion I. Community Based System and Criterion III. Children's Services)

- Priority #4 – **Evidenced Based Practices and Practice Based Evidence:** To support the development of Evidenced Based Practices including peer support for family and youth, promote best practices in work with youth in transition and/or homeless (especially under McKinney Vento, IDEA and ADA) working with schools and children/youth who are school age, and with families of preschool age children. (Criterion V. Management System, Criterion IV. Rural and Homeless, Criterion I. Community Based System, Criterion II. Data Epidemiology and Criterion III. Children's Services)

In sum, in light of the above priorities, the Council has been mindful of and intends to continue to examine the data, trends and make recommendations specific to the Block Grant and system as a whole. To guide this work, the Council will strive to frame their recommendations based on the responses to the following questions, "How do we define success? What does success look like?"

NC Mental Health Block Grant Implementation Report - Child

1. b. Child - Summary of Areas Previously Identified by North Carolina as Needing Attention

During the State Fiscal Year 06-07, **system transformation** has addressed a number of needs resulting in positive changes which have occurred and are being sustained:

- On-going construction continues on the new regional psychiatric hospital in Butner, NC; this 432 bed facility will serve persons needing inpatient psychiatric services in both the north and south central regions of the state and is expected to open in March of 2008 and will replace two existing hospitals: John Umstead Hospital and Dorothea Dix Hospital.
- In 2006, the North Carolina General Assembly specified changes to the implementation of reform of the mental health, developmental disabilities, and substance abuse services system in House Bill 2077, Session Law 2006-142.

These changes include having a clear and concise plan for service provision and the prudent use of local and state resources. The Division has identified specific goals for the next three years, including benchmarks of progress toward the goals. This document is known as the ***State Strategic Plan for 2007-2010***. Input in development of the Plan was solicited from consumers, family members, and other stakeholders, including the NCMHPAC. A draft of the Plan was posted on the Division website for a 30-day public comment period in late spring of 2007; the final Plan now appears on the Division website.

- In state fiscal years 2006 and 2007, the Division continued the ongoing process of:
  - identifying gaps in services at the local level-including transition to best and promising service practices as well as improving penetration rates and continuity in service provision;
  - quantifying the level of all resources (Medicaid, state funds, etc.) needed and available to close such service gaps; and
  - establishing an allocation system that would help ensure funding equity, i.e., equal access to services throughout the state, among Local Management Entities.
- The Division has created and implemented various committees, communications series, trainings and interactive events to improve communication with all participants and interested individuals: a) the External Advisory Team comprised of advocates, consumers, provider trade associations, the North Carolina Council of Community Programs, and other stakeholders to provide advice and guidance on policy decisions; b) the Provider Action Agenda Committee deals with the needs of providers in the new, privatized service delivery environment; c) hosted 16 Town Meetings across the state; d) created and disseminated communication bulletins and implementation updates to inform the system; and e) created the Division's web site as a means to facilitate communication and reference for policy and events.

North Carolina

Child - Most Significant Events that Impacted the State in the Previous FY

Child - Report Summary of the most significant events that impacted the mental health system of the State in the previous FY

NC Mental Health Block Grant Implementation Report - Child

2. Child - Most Significant Events that Impacted the State Mental Health System in the Previous FY.

- The development of crisis response units around the State to ensure that every county has access to a crisis portal of entry for individuals/families in crisis and to give an update as to that coverage.
- Continued transition of service delivery from the local area MHDDSAS authorities to other public and private providers;
- The endorsement of over 1400 providers of services to children/adolescents and their families and to adults statewide.
- The recent passage of the mental health *Parity* legislation by the Senate and House; this bill requires health insurers in the state to provide the same level of coverage for treatment of post traumatic stress disorder, eating disorders, severe depression, schizophrenia and/or other mental illnesses as they do for physical illnesses. While this bill may not cover all diagnoses, nature or need of children/adolescents or for those adults with less chronic needs such as maternal depression, it is landmark legislation for North Carolina that can be expanded in future years.
- As the result of the State Consumer and Family Advisory Committee being codified in law (S.L.2006-142 Section 5), the old State Consumer and Family Advisory Committee was disbanded and a new committee, appointed in accordance with the new law, began operations on November 9, 2006; the State Consumer and Family Advisory Committee is a self-governing and self-directed organization that advises the Dept. of Health and Human Services and the General Assembly on the planning and management of the State's public mental health, developmental disabilities, and substance abuse services system and works directly with the Executive Leadership Team of the Division. More information follows regarding local Consumer and Family Advisory Committees and the State Consumer and Family Advisory Committee.
- Through a contract with consultants, the Division developed a long range plan report and a cost model to determine the cost of providing needed services in the community. Concurrent with this long range plan and cost model, the Division developed the finance and allocation model to assist in determining how services might be funded and how to reduce funding variability among Local Management Entities (LMEs) to ensure an equitable distribution of resources.
- The MHDDSAS Commission and the Division began a Workforce Development Plan, using a regional focus group process with stakeholders that will be completed and implementation steps begun in SFY08.
- Completed and disseminated the three year State Strategic Plan and developed a consumer brochure by and for consumers on the Plan.
- Continued recurring funding for expanding System of Care statewide, including sustaining the state level coordinator, funding for 30 LME SOC Coordinators and training/technical assistance regarding SOC essential elements, such as for Child and Family Teams.

- Continued recurring funding for 18 LME School Care Coordinators for Governor's Child and Family Support Team school initiative in 101 lowest performing schools in 21 LEAs and 22 counties.

The North Carolina Mental Health Planning and Advisory Council members provided information regarding achievements, challenges/needs, and priorities is detailed in the earlier section pertaining to the Mental Health Planning Council role, activities, membership composition, etc.

Mental Health Reform and Transformation – There have been significant changes taking place in the public mental health/developmental disabilities/substance abuse services system in the last several years: submission, and approval of new and modified service definitions and benefit packages to the Centers for Medicare and Medicaid Services (CMS) that reflect evidence-based best practice, implementation of person-centered planning training, increased involvement by consumers and family members in the service delivery system. In January 2006, Division Director sent out a communication bulletin informing everyone that CMS had approved the Medicaid State Plan Amendment which the Dept. of Health and Human Services submitted to provide for new and enhanced services for individuals with mental illness and substance abuse disorders. The approval of the new and modified service definitions is a critical milestone in our efforts to transform the public mental health, developmental disabilities, and substance abuse services system. These new definitions provide the clinical foundation for transforming the community service array and providing more effective services to consumers. Many of the new definitions represent evidence-based practices, or provide a platform through which evidence-based, emerging, and promising practices can be delivered. The new service array has been designed to improve consumers' access to services and increase consumers' choice of provider since all providers of these services will directly enroll in the Medicaid program.
The implementation of the new service definitions promote in home and in community based services and supports for children, youth and families and require coordination with other child-serving agencies such as education, social services, health and the courts as well as informal supports such as mentors, clergy and significant others. These services also reflect or allow for evidenced based practices such as trauma informed cognitive behavioral therapy (TF-CBT), DBT and brief treatment interventions as components of Intensive in Home Services and multi-systemic therapy (MST) to be provided. Among other definitions, Diagnostic and Clinical Assessments, Community Support (integrated service coordination functions with rehabilitative skill building), Child and Adolescent Substance Abuse Intensive Outpatient (SAIOP) treatment services are becoming more available as providers are trained, endorsed and enrolled.

North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS)– The NC-TOPPS was created and the means by which the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) measures outcomes and consumer and family perspectives of behavioral health services. NC-TOPPS captures key information on a consumer's current episode of treatment. NC-TOPPS aids in evaluation of active treatment services and

provides data for meeting federal performance and outcome measurement requirements. NC TOPPS had been activated earlier for individuals with substance abuse issues. Since July 1, 2005, NC TOPPS began capturing data for adults with mental illness and children/youth with or at risk of serious emotional disturbance. The NC MHPAC has carefully reviewed and made recommendations to modify both the items and methodology used in use of/reporting NCTOPPS. This review and monitoring will continue in the next SFY.

Consumer and Family Advisory Committees (CFACs) — One key to reform is the active participation of members of communities - the individuals and family members affected by mental illness, developmental disabilities and/or substance abuse that can best represent the perspective and needs. Two major efforts aimed at increasing consumer and family involvement were called for in the state's reform plan. One was the creation of Consumer and Family Advisory Committees for each local program in North Carolina. The other effort involved the Secretary of the Department of Health and Human Services (DHHS) appointing a State Consumer and Family Advisory Committee to work directly with system leadership to implement reform. With the State Consumer and Family Advisory Committee being codified in law as indicated earlier, members to this group are now appointed by: the President Pro Tem of the Senate, the Speaker of the House of Representatives, the North Carolina Council of Community Programs, the North Carolina Association of County Commissioners, and the Secretary of the Department of Health and Human Services. Currently, there are active Consumer and Family Advisory Committees in each Local Management Entity catchment area.

Specific to consumer advocacy, the Division's Advocacy and Customer Service section continues to be instrumental in the Department's commitment to customer service by training Division staff; responding to customer inquiries, complaints, requests for information and Medicaid recipients' appeals regarding services; and providing technical assistance to Local Management Entities as they develop customer service offices. Local offices are responsible for promoting public information about services and rights, supporting local Consumer and Family Advisory Committees (CFSACs) and human rights committees and conducting rights investigations. The Division's Advocacy and Customer Service section also provides advocacy services to consumers who receive care and treatment in state operated facilities. Advocacy includes training of consumers, family members and facility staff and conducting rights investigations.
t
The ***Child Mental Health Plan*** (2003), developed by the State Collaborative for Children, Youth and Families, continues to be implemented as a part of overall system transformation found at http://www.ncdhhs.gov/mhddsas/childandfamily/index-new.htm Implementation efforts support the foundation of reform by creating opportunities for and supporting authentic input from children, youth and families a voice and focusing on collaborative and flexible services and supports delivered within the life environment of the child. The plan also addresses the issues and recommendations in the *Report of the Surgeon General on Mental Health* and the report of the *President's New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America*. These issues include building the science basis for treatment,

overcoming stigma, improving public awareness of effective treatment, ensuring a qualified supply of providers, using evidence-based interventions, addressing cultural issues, improving access, and tailoring available resources to reduce barriers to effectiveness. The essential recommendations, which bridge the Surgeon General's Report and previously commissioned studies, include increasing community capacity, decreasing reliance on state operated services, establishing local accountability, establishing "bridge" funding, ensuring consistency and standardization of services state-wide and focusing on the primary consumer through child and family centered plans for supports and services.

The essential components of the plan include: decreasing fragmentation in service delivery, ensuring services are driven by the needs and preferences of children and families, elimination of disparities in mental health care through provision of culturally proficient services, prevention and early intervention, and advancing the use of evidence-based practices and emerging best practices organized within a System of Care (SOC) practice framework.

As a history note, implementation of the Child Mental Health Plan began in the fall of 2003 with the appointment of the program manager and the development of a detailed implementation plan, including timelines and the identification of staff resources. During the first implementation year, it was necessary to lay considerable groundwork in order to integrate tasks with ongoing mental health system reform. By the end of state fiscal year 2004-2005, accomplishments included: the implementation of the communications plan that addresses multiple audiences through mass media; implementation of outcome measures selected for children and adolescents; continued work on the development of a comprehensive assessment tool and initial work on coordinated interagency process; a continued review of current evidence based and emerging best practices, legislation, rules and funding that apply to the delivery of services for children and their families; and strengthening relationships and service implementation with a wide variety of child-serving partners. Recent highlights of accomplishments are summarized below.

Plan Administration and Communication **—** During the past year, the DHHS and DMHDDSAS web pages have been updated and become easier to navigate located at http://www.ncdhhs.gov/mhddsas/ . The NCMHPAC web page has been updated at http://www.ncdhhs.gov/mhddsas/mhplanning/index.htm . The Division's Child and Family web page has been redesigned to reflect the afore mentioned tenants and SOC framework and continues to be updated with current information, practice guidance and web links for easier access. In addition, the Child Planner and other Division staff worked closely with DHHS staff to revise and update a customer friendly, easy to navigate web based information system. The NC CARELINE 1-800 access help line has developed an internet resource listing by county of all the human services and supports, both formal and informal for improved consumer access through this web link http://www.ncdhhs.gov/mhddsas/consumers.htm . Additional improvements are being made, such as links and resource information for military families and those in the National Guard through the RSVP – Returning Support for Veterans Program funded by the state legislature and promoted by the Governor and First Lady, Mrs. Easley. It is

estimated that approximately 1000 individuals rotate in/out of NC daily at this time due to the war in Iraq. NC has one of the largest populations of active, veterans and national guard units among a few other states. The web additions also include easily accessible disaster preparedness and recovery information.

~Child Mental Health Evidence-Based Practices

Community Capacity and the Service Array –Evidenced Based Practices and Practice Based Evidence – Progress has been made with the recent elimination of administrative and fiscal barriers in the delivery of services through the comprehensive treatment services program (CTSP) as described in the Division's Communications Bulletin #34 (initiated in August 2004 as amended June 2005). Implementation guidelines were disseminated to LMEs, providers, families and other stakeholders.

Trust funds appropriated by the legislature were distributed to the LMEs to support expansion of community based and crisis services statewide. Progress is being made in strengthening crisis response and provider competencies in best practice service components, such as first responder functions, supported through the expanded array of service definitions. Communities are engaging local hospitals, health care professionals and local enforcement as steps are taken to improve access and timely response.

Transition from current Medicaid service array to the new and modified services was addressed using multiple strategies. In addition to distributing trust funds to facilitate development of these community based services, training developed for initial orientation and in-depth practice for trainers of trainers was developed and held January-June 2005. Training continued to support the development of the full array during state fiscal year 2006-2007. Efforts continue helping communities develop adequate crisis and acute services across the state.

The MHDDSAS Commission has revised the rules for the residential spectrum of the service array in support of improved staffing ratios. The Division is working to align the service array across child serving agencies including the Division of Public Health, Division of Social Services and the Departments of Juvenile Justice and Delinquency Prevention and Public Instruction (includes IDEA, school performance and improvement Plans, vocational education).

Supporting the essential components of a statewide System of Care (SOC) is core to this plan. Legislative funding to expand SOC in each community was appropriated to the DMHDDSAS. SOC Coordinators have been established in each LME along with sustained funding for a state level coordinator. Additional progress is noted below.

Overall System Efforts – The Division of Medical Assistance and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services received a grant to support a Mental Health Systems Transformation project in North Carolina in October, 2004. The goal of the Mental Health Systems Transformation Project is to assist four local management entities to develop the infrastructure necessary to support the

implementation of evidence-based practices within their local communities. This Project fits within the overall science to service initiative mentioned above and will further advance the Division's efforts to provide evidence-based practices for consumers and their families. This Mental Health Systems Transformation Project brings together the North Carolina Division of Medical Assistance and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with community stakeholders, including consumers, the North Carolina Governor's Institute on Alcohol and Substance Abuse and national experts.

Related Impact on Children/Adolescents and their Families – While this effort its initial focus has targeted EBPs for adults, youth in transition are among those who can benefit from these EBPs. In addition, those communities who are able to implement EBPs for adults will have experience in establishing practice models and sustaining fidelity. This sets a foundation for implementing an array of EBPs across ages and abilities in the future of those communities in accordance with the State Plan.

North Carolina Practice Improvement Collaborative (PIC) – In 2005 the *North Carolina Practice Improvement Collaborative (PIC)* was formed to provide guidance in determining the future evidence based services and supports that will be provided through our public system. Division Director Mike Moseley appointed 60 people to serve as advisors to the Division. The advisory group is a partnership between consumers, clinicians and researchers. Science informs the provision of services, and the experiences of consumers, family members, and service providers who have/will continue to guide research on future services and supports that might be provided. Information on this link *http://www.governorsinstitute.org/index.php?option=com_content&task=view&id=34&Itemid=67* .

Comprised of representatives of all three disabilities, the NC PIC will continue to meet quarterly to review and discuss relevant programs. Annually, the group presents a report of prioritized program recommendations to the Division Director at a public forum. This forum, defined as the North Carolina Practice Improvement Congress, features brief educational descriptions of the practices being recommended by the NC PIC in its report.

The mission for the NC PIC is to ensure that each time any North Carolinian—whether a child or an adult, a member of a majority or minority, from an urban or rural area—comes into contact with the DMHDDSAS system, that the individual will receive excellent care that is consistent with our scientific understanding of what works (New Freedom Commission on Mental Health, 2003).

CMHS has sponsored a collaborative effort with Duke University, NC providers and other resource experts to develop an EBP tool kit for Multidimensional Therapeutic Foster Care Treatment. In November 2006 and February 2007, Dr. Barbara Burns, Duke University, is among the NC PIC members. Dr. Burns and Dr. Jeanne Rivard from the National Research Institute (NRI) of the National Association of Mental Health Program Directors (NASMHPD) provided a national scan and status report to the NC PIC on EBPs for children and adolescents with serious mental health needs.

The Second Annual Practice Improvement Collaborative Congress was held in Raleigh, on May 14, 2007. Dean Fixsen, Ph.D, among other expert resources discussed "*The Science of Implementation: How to establish Evidence-based Services and Supports in our Communities."* Results of this meeting came the Practice Improvement Collaborative's recommendation that the Division adopt the following Evidence Based Practices and supports for consumers and their families: Trauma Focused Cognitive Behavioral Therapy (TF-CBT for Child MH), Therapeutic Foster Care (Child MH) Supported Employment (Mental Health), START Model (Systematic, Therapeutic, Assessment, Respite and Treatment) for those in crisis who are diagnosed with a Developmental Disability), MATRIX (Methamphetamine and other stimulant drug addiction), Seeking Safety (Substance Abuse and Trauma with documented improved child/adolescent outcomes), and Strengthening Families (Substance Abuse Prevention with documented improved child/adolescent outcomes).

Strengthening Families has been successfully implemented in three different counties with 25 new providers trained by September 2007. Trauma Focused Cognitive Behavioral Therapy (TF-CBT) for children and youth who have experienced sexual abuse is currently being implemented in a 28 county pilot in the eastern most coastal counties in NC, with emphasis on developing a well-trained sustainable workforce indigenous to the area and the provision of ongoing access to telephonic and web-based clinical and peer supervision and mentoring. This effort has demonstrated that providers are interested in implementing EBPs, will participate in the necessary training and supervision to do so and child and family outcomes improve.

North Carolina State Mental Health Trust Fund Appropriated to Increase Community Capacity – The North Carolina General Assembly established a Mental Health Trust Fund in SFY 01-02. These funds have been used each year to provide one time start-up funding to increase community service capacity. For example, in SFY 06-07, the Division issued requests for applications from Local Management Entities in collaboration with contracted service providers to fund projects designed to assist with one-time non-recurring needs in SFY 06-07 and 07-08 related to the provision of community services to consumers. Initiatives that were funded included increasing local capacity to address the service needs of adults with mental illness, children with mental health and/or substance abuse needs, adults with substance abuse needs and women with substance related disorders who are pregnant and/or their young children.

Taking System of Care to Scale Statewide – Supporting the essential components of a statewide System of Care (SOC) is core to State Plan and State Child Mental Health Plan. Legislative action during the 2005 long session appropriated recurring state funding to expand SOC in each community. These recurring state funds have been allocated through the Division of MHDDSAS to each of the 30 LMEs. SOC Coordinators have been established and sustained in FY 06-07 in each LME along with sustained funding for a state level coordinator. By June 30, 2007, 27 System of Care Coordinators were in place in Local Management Entities. The SOC Coordinators' core functions include the following: involvement in the Community Collaborative, youth and family involvement

and leadership, Child and Family Teams for Person-Centered Planning, interagency collaboration, SOC Training and technical assistance, and quality management processes.

Technical assistance to LME System of Care Coordinators was provided and included one statewide meeting, quarterly regional meetings and site visits to local community collaboratives upon request. A new quarterly reporting system effective July 1, 2008 will track participation, priorities and progress toward outcomes of each community collaborative as well as the System of Care activities related to the six core functions of the LME System of Care Coordinator position.

In addition, state funds appropriated to extend implementation of SOC, have been used to develop and implement a cross-agency child and family team training from the family's perspective. Funds have been used to disseminate the training beginning with the Introduction to Child and Family Team Training in March and April 2007 and Skills for New Trainers offered twice in May 2007. Families and youth along with Public Academic Liaisons (PALs) partners at University of North Carolina at Greensboro (UNC-G) and North Carolina State University (NCSU) and state departments and agencies participated in this effort and will continue to do so in the next SFY. SOC Coordinator Training Schedule has been planned through June 2008. These will include: Introduction to Child and Family Teams, Train the Trainer in July and August 2007; Child and Family Team Facilitation Training in September and October 2008; Child and Family Team Facilitation Training, Train the Trainer in November and January 2008; and Strength-Based Leadership Training-February-May, 2008. The NC State Collaborative for Children, Youth and Families will continue to pursue mechanisms to sustain SOC training efforts.

Statewide implementation of System of Care principles and practices continued during the 2006 State fiscal year. Use of state and federal block grant funds have been used to do so at the state and community levels. The Comprehensive Treatment Services Program, first legislated in 2001, requires child-serving agencies (mental health, juvenile justice, social services, schools, and the courts) to form Local Community Collaboratives in partnership with families, family advocacy organizations and community stakeholders. As of Jun 30, 2007 there were 56 active Local Community Collaboratives in North Carolina that met an average of 10 times each throughout the year. As of June 30, 2007, twenty-nine of the thirty Local Management Entities submitted to the Division, Local Memorandum of Agreements to carry-out the Comprehensive Treatment Service Program.

School Based Mental Health and Substance Abuse Services – State funding for ***school based health and behavioral health services***, including mental health and substance abuse treatment services, and school nurses was increased through state appropriation this SFY. These services are coordinated with Division of Public Health, the state Department of Public Instruction, NC Healthy Schools initiative and the Division of MHDDSAS with the respective local community agencies. Improved outcomes for individual children and schools at large have been demonstrated in NC and nationally when school health is accessible to children and youth in schools.

In addition, recurring state appropriations were secured for both the Division of MHDDSAS and Social Services in establishing two additional positions responsible for Care Coordination and facilitating Child and Family Teams as part of the Governor's School Initiative for Child and Family Support Teams. These teams exist in 101 of the lowest performing elementary, middle and high schools in 21 LEAs statewide. The Child Planner participates in the Governor's Core Team, State Advisory Committee, evaluation and in the regional and local training and technical assistance provided to promote success of this initiative. In SFY 06-07, 18 LME Care Coordinator positions were established and funded to support this initiative. State funds appropriated for these positions leveraged federal funds to fully implement 18 full time equivalent positions in 15 different LMEs. These positions and services will continue in the next SFY with initial evaluation results reported in 2008-09.

A second Shared Agenda Seed Grant was awarded to NC www.sharedagenda.org . This seed grant jointly funded through the National Association of Special Educators and Directors (NASEDE) and the National Association of Mental Health Program Directors (NASMHPD). Three communities were funded to complete strategic planning for school based mental health services and supports; included were Buncombe, Chatham and New Hanover counties. Family, youth, the Division's Child Planner, Department of Public Instruction staff, community planning members will present its work and outcomes related to this effort and child and family team curriculum development in October 2007. A new seed grant application was submitted in June 2007 to fund additional community planning efforts. It is hoped that additional funds will be leveraged to extend this effort.

Child Maltreatment Prevention, ***Early Intervention and Treatment*** – A Leadership Team was established by a Task Force led by the Secretary of DHHS and a member of the NC Pediatric Society. Division and community staff have worked collaborative and in leadership roles in the area of mental health and substance abuse prevention, early intervention and treatment, child mental health screening instituted in domestic violence shelters with an evaluation component to determine effects, early childhood mental health comprehensive design, maternal/perinatal depression and response and family support to military families and their children to implement the Task Force's recommendations. Connecting the dots between prevention of neglect and abuse and providing effective trauma informed treatment to improve child and family outcomes is critical for NC. A grant application to Administration for Children and Families was submitted this SFY for three year funding to integrate and coordinate such services in Robeson county. If funded, implementation will begin in 2008.

The Joint Legislative Oversight Committee on MH/DD/SAS

The North Carolina General Assembly has been actively involved in reform efforts of the public system of mental health, developmental disabilities, and substance abuse services, beginning with the establishment of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services to oversee system reform. The Legislative Oversight Committee was instrumental in the creation and ratification of the mental health reform statute (House Bill 381: An Act to Phase in

Implementation of Mental Health System Reform at the State and Local Level). Since the enactment of the reform legislation, the Legislative Oversight Committee has met on a regular basis to receive input from the leadership of the Department and the Division and from the public on the status of the reform efforts. The Division provides quarterly reports to the Legislative Oversight Committee on matters related to implementation of the reform.

Other Legislative Updates

Some other legislative provisions that have been drafted by North Carolina's General Assembly in Session 2007 include:

- The development of a uniform screening tool to be used when offenders are booked; this will be a joint effort of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Local Management Entities, public health departments, and county sheriffs (Section 10.49{f}).
- The development of a uniform screening tool to be used by Local Management Entities to determine the mental health of any individual admitted to any long-term care facility within a Local Management Entity's catchment area (Section 10.49 {k}).
- The proposed implementation of an 18-month pilot program during the 2007-08 fiscal year to test a mechanism to reduce psychiatric hospital use by holding a Local Management Entity financially and clinically responsible for the cost of that use and by providing additional resources to build community capacity. The Department of Health and Human Services shall select at least three Local Management Entities that use the same hospital for the referral of clients and that submit a proposal to participate in the pilot to the Division no later than mid-October, 2007. The proposal shall include a plan by the Local Management Entity to reduce hospital use by a specified amount and an explanation of how the Local Management Entity expects to accomplish this goal (Section 10.49 {s}).
- Recurring state funds have been appropriated to sustain the 30 SOC Coordinators among the 25 LMEs. Statewide SOC implementation will be sustained.
- Recurring state funds have been appropriated to sustain the 18 LME Care Coordinators for the Governor's School Child and Family Support Team initiative in 101 schools and 21 LEAs. Implementation of these 4 person teams in each of the 101 schools/communities will be sustained; evaluation and training efforts will continue to document child and family outcomes and build team competencies.

North Carolina

Child - Purpose State FY BG Expended - Recipients - Activities Description

Child - A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

NC Mental Health Block Grant Implementation Report - Child

3. Child - Purpose State FY BG Expended - Recipients and Activities Description

Child - A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

North Carolina's total Mental Health Block Grant expenditures (revenue drawn) for SFY 2006-07 on the year end authorized report were $10,736,148.81, which includes both direct and non-direct service activities. This total does not include Medicaid or local funds that are used in funding services. Non-direct service activity reflects contracts, technical assistance activities, Mental Health Planning Council activities, and administration. Non-direct service activity expenditures for the SFY 2007 reporting year were $1,418,493. The majority of the Mental Health Block Grant funds for children and adolescents with serious emotional disturbance was and will continue to be allocated to Local Management Entities. Funds will be used to provide continued support for contracts to provide necessary treatment services and supports that are needed in local communities, especially for those people who aren't Medicaid recipients and who have little or no income. At the end of this section on Mental Health Block Grant expenditures, there is a table detailing final expenditures of Block Grant funds allocated to each of the 30 Local Management Entities in the State. Mental Health Block Grant funds were also used to contract with various consumer and family advocate organizations and higher education institutions extending necessary workforce development with our Public Academic Liaisons (PALs), as described in greater detail below.

North Carolina's Mental Health Block Grant final award for FFY 2007 was $10,916,330. North Carolina received an increase of $441,418 or 4.2% in the Community Mental Health Services Block Grant Plan final allocation amount for 06-07; however, because it was received so late in the fiscal year, the increase was reflected in SFY 07-08 (the actual allocation for SFY 06 was $10,474,912) State-level administrative expenses will be no more than the allowed 5% of any given grant award.

The Division's Integrated Payment and Reporting System or IPRS limits the use of Mental Health Block Grant funds to specific target populations (adults with severe and persistent mental illness and adults with serious mental illness). The IPRS is designed to be a Health Insurance Portability and Accountability Act or HIPAA-compliant, multi-payer system integrated with the state's Medicaid payment system, enabling providers of services the ability to send one bill to the state for payment of state or federal monies. This payment system ensures that Mental Health Block Grant funds are not used to provide inpatient treatment.

Examples of the types of services that have been supported by Block Grant funds include: diagnostic and comprehensive clinical assessments, evaluations, medication management, treatment, family psycho education, respite, as well as other services/supports in the North Carolina covered service array. Block Grant funds have also been used to continue funding peer and family support, education to eliminate barriers to services in public systems such as schools, college campuses and physicians' practices through National

Alliance on Mental Illness (NAMI) NC Young Family Initiative. In addition, training has been provided to law enforcement regarding crisis intervention with children/youth with serious emotional disturbance and their families, including recognizing risk for and preventing suicides. Gatekeeper training using the ASIST curriculum has been implemented using these funds through a contract with Mental Health Association in NC (nationally known as Mental Health America, Inc).

Mental Health Block Grant funds were also used to support the new services that went into effect in mid March 2006, such as Community Support, Community Support Team, Intensive In-Home Services, Mobile Crisis Management, Mutlisystemic Therapy (MST), Day Treatment and Diagnostic Assessment through the IPRS for children/youth with serious emotional disturbance and their families.

The NCMHPAC has received reports from the Division and its' contractors who utilize Block Grant funds include NAMI (National Alliance on Mental Illness) Child and NAMI Adult, the North Carolina Mental Health Consumers Organization (NCMHCO), the Mental Health Association, Eastern Carolina University (this contract with Eastern Carolina supports a social work degree program with an emphasis on preparing students to work with those who are deaf or hard of hearing and who have mental illness), University of North Carolina at Chapel Hill School of Social Work Behavioral Healthcare Resource Program, University of North Carolina Dept. of Psychiatry (this contract provides for students to receive stipends who want to complete internships with the Division), and the Duke Child and Family Health Center. Contractors participate in the Council meetings, receive recommendations and provide reports on work scopes.

The NCMHCO Executive Director provided a contract report about this organization earlier at one of the Mental Health Planning and Advisory Council meetings as they are a recipient of Mental Health Block Grant funding. She discussed other activities/events as follows that utilize Block Grant monies: NCMHCO also offers Wellness Recovery Action Plan (WRAP) Training sessions in each region of NC. This year, NCMHCO conducted an After-Care WRAP Program to ensure consumers are benefiting from WRAP and how to focus on the individual WRAP plan. They also offer a Leadership Training Academy in Raleigh, NC each December. The Leadership Academy promotes consumer involvement in Leadership and Civic Participation throughout the year. It is a self help program that teaches organizational skills and encourages individuals to become self advocates and educates the community on issues concerning behavioral health sciences. Transition age youth have been included in this funding and recovery effort.

The Mental Health Association (MHA) in North Carolina was first organized in 1914 and chartered in 1939. They are the state's largest private, non-profit mental health organization addressing advocacy, education and service. Their mission is to promote mental health, prevent mental disorders, and eliminate discrimination against people with mental disorders. These goals are accomplished through community advocacy, education and service. MHA affiliates consist of both staff and volunteers and currently serve over 50 North Carolina counties.

The contract with the North Carolina Chapter of the National Alliance on Mental Illness helps to provide services such as support groups and educational programs (i.e., "Families and Teachers as Allies, NAMI on campus," etc.). The mission of NAMI North Carolina is to improve the quality of life for individuals and their families living with the debilitating effects of severe and persistent mental illness. They work to protect the dignity of people living with brain disorders through advocacy, education, and support. Membership in the affiliates in North Carolina consists primarily of family members of people who have mental illness, families with children who have serious emotional and mental disorders and also includes consumers, friends, and professionals. Affiliates typically have monthly support meetings and/or educational and business meetings. When mental illness strikes, it is usually surrounded by confusion and isolation. Support groups can provide an opportunity to talk with other people who have "been there" and who understand what you are facing. General meetings have speakers on issues important to members. A children and families track was developed and held during the statewide and regional conferences in SFY07. A newsletter and child specific information has been developed and disseminated widely through the course of the year.

North Carolina has adopted several goals from the 2003 President's New Freedom Commission on Mental Health and one of them focuses on improving and expanding the workforce. One means of accomplishing this is to train providers in service delivery that helps people reach their goals on their journey to recovery and self determination. The Behavioral Healthcare Resource Program (BHRP) at the University of North Carolina in Chapel Hill (through a contract with the Division which utilizes Block Grant funding), assists with training such as this, staff development, technical assistance and leadership consultation. This program is part of the Jordan Institute for Families in the UNC School of Social Work and acts as a bridge between a research–oriented academic setting and community professionals.

Information about the Mental Health Block Grant funds expended by Local Management Entities for services for children with serious emotional disturbance and their families is provided in the table on a following page.

Since this section of the Implementation Report addresses monies expended during SFY 2006-07, it seemed appropriate to include an update on North Carolina's Maintenance of Effort/State Expenditures for Mental Health Services Report. States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory Maintenance of Effort (MOE) requirements.** MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant. Child set aside* is based on 1994 funding levels.

MOE information reported by:

State FY ___X_____ Federal FY_____

State Expenditures for Mental Health Services

Actual FY 2005	Actual FY 2006	Actual FY 2007
$251,939,348	$274,924,661	$432,482,015

***Section 1913(a) of the PHS Act**
****Section 1915(b(1) of the PHS Act**

Set Aside for Children

*State Expenditures for MH Services:

*Calculated FY 1994 *	Actual FY 2006	Actual FY2007
*$46,773,250	*$133,332,002	*$241,933,373

SFY 06-07

Child - Final Expenditures of Mental Health Block Grant Funds

Local Management Entities	Child
Alamance-Caswell-Rockingham Mental Health DD/SAA	35,602
Albemarle Mental Health Center DD/SAS	17,940
Catawba County MH Services	24,885
CenterPoint Human Services	87,214
Crossroad Behavioral Healthcare	35,022
Cumberland County Mental Health Center	99,765
The Durham Center	31,018
Eastpointe	57,231
Edgecombe-Nash MH/DD/SAS	14,504
Five County	132,655
Foothills Mental Health DD/SAP	55,724
Guilford Center for BH/DS	127,069
Johnston County Area Mental Health MR/SAA	13,745
Mecklenburg Mental Health and Community Service Department	2,066
Neuse Center for Mental Health DD/SAS	0
New River Behavioral HealthCare Services	0
Onslow County Behavioral HealthCare Services	23,069
Orange-Person-Chatham (OPC) Mental Health DD/SAA	40,587
Pathways Mental Health DD/SA	71,692
Piedmont Area Mental Health MR/SAS	98,980
Pitt County Developmental Disabilities & Substance Abuse Services	30,686
Roanoke-Chowan Human Services Center	16,566
Sandhills Center for MH/DD/SAS	140,594
Smoky Mountain Center for Mental Health DD/SAS	41,886
Southeastern Center for Mental Health/DD/SAS	44,776
Southeastern Regional for Mental Health DD/SAS	55,968
Tideland Mental Health Center	5,554
Wake County Human Services	1,589,486
Western Highlands	96,353
Wilson-Greene Area Mental Health MR/SAS	17,940
TOTAL	3,008,577

*The Integrated Payment and Reporting System (IPRS) ensures that state and federal funds are used to reimburse the local programs for community based services to priority populations including children with serious emotional disturbance.

Section II. Performance Indicators – Child

Child

Performance Indicator Table for Implementation Report 8/21/2007 11:41:05 AM

Upload Planning Council Letter for the Implementation Report
~ Draft at the Nov 2nd Council meeting.

Appendix B (Optional) ~ Upload Table 1 - *Spheres of Influence of NC Mental Health Planning and Advisory Council Membership:A Summary of Over 60 Different Existing Opportunities For NC Consumer, Youth and Family Voice, Involvement and Advocacy in NC*

Upload explanations for the Implementation Report

History Upload explanations for the Implementation Report

TABLE 1

Spheres of Influence of NC Mental Health Planning and Advisory Council Membership: A Summary of Over 60 Different Existing Opportunities For NC Consumer, Youth and Family Voice, Involvement and Advocacy in NC
Updated - June 2007

State Level	Community Level Activity and/or Community Stakeholders involved in State/National Work Scope	Both
NC DHHS / Division of MHDDSAS		
DMHDDSAS/Advocacy and Customer Services Section – Customer Empowerment Team & State Facility Advocates	-Regional customer empowerment liaison network -State facility client rights/human rights committees	X X
State Consumer Family Advisory Committee (State CFAC)	Local Consumer Family Advisory Family Advisory Committee(CFAC)	X
NC Council on Community MHDDSAS Programs – Board of Directors	Local Management Entity/Area Authority Advisory Boards	X
NC Commission for Division of MHDDSA Services	Establishes state and community rules governing practice.	
NC Commission for Division of Social Services	Establishes state and community rules governing practice.	
NC Council on Developmental Disabilities	Self- Advocacy and Self Determination support networks	X
Governor's Advocacy Council for Persons with Disabilities (GACPD) - Includes Protection and Advocacy for Individuals with Mental Illness (PAIMI)	Note: Currently pending move out of Department of Administration to a non-governmental oversight.	
NC Mental Health Planning & Advisory Council	Impacts & relates to LMEs, local CFACs. providers, consumers & other stakeholders	
National-State Advocacy Opportunities		
National Alliance on Mental Illness in NC (NAMI/NC)	NAMI/NC Community Affiliates (includes Family to Family; Young Families Initiative)	X
Mental Health Association in NC (MHA/NC)	MHA/NC (includes housing)	X
National Federation for Children's Mental Health - NC Chapter (NC Families United & youth*)	Regional and community networks	X
National Coalition of MH Consumer/Survivor Organizations		X
ARC of NC, Inc.	Regional and community affiliates	X
National Commission on Correctional Healthcare		
Autism Society of NC, Inc.	Community Network	X
Easter Seals/United Cerebral Palsy of NC, Inc.	Regional and community network	X
National Assoc. of Foster Parents – NC Assoc. of Foster & Adoptive Parents		X
National Assoc. of State Mental Health Program Directors (NASMHPD) – all divisions		
National Assoc.of Special Ed. Directors & Educators (NASEDE)		
IDEA Shared Agenda Practice Communities - School Based Mental Health and Behavioral Health Services	State & community plans in action	X
American Academy of Pediatrics – NC Pediatric Society	Communities of Practice (co-located services)	X

North Carolina Specific Advocacy		
State Level	**Community Level**	**Both**
NC Treatment Outcomes Program Performance Scale (NCTOPPS) & Quality Management Advisory Committee		
Practice Improvement Collaborative (PIC) on Best Practices for Review & Implementation in MHDDSA system		
MHDDSAS "Secret Shopper" Statewide Monitoring Project		X
NC Covenant for Children	Community Network & Advocacy	X
Coalition 2010 – NC Coalition for Persons Disabled with Mental Illness, Substance Abuse Federation, DD Consortium		X
NC Mental Health Consumers' Organization	Community Network & Leadership Academy	X
Governor's Youth Advocacy and Involvement Office (YAIO)	Community Network	X
North Carolina Families United	Community Network & Policy Panel	X
Powerful Youth	Community Network	X
Strong Stable Youth Speaking Out (SAYSO)	Regional and community network	X
NC Collaborative for Children, Youth & Families	Local Community Collaboratives	X
Brain Injury Association of NC (Traumatic Brain Injury	Community Network	X
Exceptional Children's Assistance Center (ECAC)	Regional and community network	X
Family Support Network of NC (FSN/CN)	Regional and community network	X
Action for Children (former NC Child Advocacy Institute)		
NC Low Income Housing Coalition		
Division of Public Health – Parent Advisory Committee		
Commission on Children with Special Health Care Needs	SCHIP in NC-Health Choice; Birth up to age 19	
Peer Support Specialist Delineation Study Committee		
Broughton Hospital Client Rights Committee		
Crisis Intervention Training for Law Enforcement Officers	Pitt, Wake, Mecklenburg, Western Highlands	X
Going Home Initiative for Aftercare Planning (Re-entry)	Pitt County	X
NC Partners in Justice – bridges co-occurring prisoner needs		X
NC Div. of Prisons (DOP) Mental Health QA Committee		
NC Div. of Prisons HS Policy Review & Revision Committee		
NC Division of Prisons Transitions Workgroup	Community planning	X
Homeless Sex Offender Taskforce	Community planning	X
Recovery, Inc	Community network	X
Homeless Coalition	Johnston, Guilford, Wake, Richmond	X
Human Services and Interfaith Councils	Johnston, Guilford, Wake, Richmond	X
Child and Family Team from a Family Perspective - Training		X
WRAP - Training		X
Local Management Entity Client Rights Committee	State & Community review & implementation	X
Public School Systems – state & local boards	School Health Advisory Councils	X
Positive Behavior Support (PBS) Advisory Committee	Local Education Agency	X
NC Council for Exceptional Children		X
NC Interagency Coordinating Council for Children B-5 w/Disabilities and Their Families	Regional and Local Interagency Coordinating Councils	X
SUCCESS, Inc. & Parent Voice	Guilford county, Mecklenburg county	
Coalition Against Underage Drinking	Regional, Local and Campus coalitions	X
Family Network for Substance Abuse Prevention & Treatment		X

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	181,771	185,674	185,674	180,814	97.38
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: To meet the community based service needs of adults with serious mental illness

Target: The target for FY 2006-07 was 185,674

Population: Adults with serious mental illness

Criterion: 2:Mental Health System Data Epidemiology
3:Children's Services

Indicator: The number of adults with serious mental illness enrolled with a Local Management Entity and receiving community based services

Measure: The number of adults receiving services in programs provided or funded by the state mental health agency

Sources of Information: Basic Table 2A, Profile of Persons Served, All Programs by Age, Gender, and Race/Ethnicity

Special Issues: Data about the gender, age, and race/ethnicity are presented in detail in the earlier section of this Implementation Report pertaining to Treated Prevalence.

Significance: Assuring access to services for adults with a serious mental illness is a primary goal of the Mental Health Block Grant legislation

Activities and strategies/ changes/ innovative or exemplary model: The activity plan or strategy is to make services available to more adults who have serious mental illness

Target Achieved or Not Achieved/If Not, Explain Why: This target was not achieved due to a decrease in the number of adults being served.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	11.74	12	12	12.06	99.50
Numerator	1,343	1,345	--	1,336	--
Denominator	11,443	11,177	--	11,074	--

Table Descriptors:

Goal: To decrease the rate of readmission to State Psychiatric Hospitals within 30 days of discharge.

Target: The target for FY 2006-07 was 12%.

Population: Adults with serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: The percent of adults who are readmitted to State Psychiatric Hospitals within 30 days of discharge.

Measure: The number of adults readmitted to a State Psychiatric Hospital within 30 days of discharge

Sources of Information: Table 20A Non-Forensic (Voluntary and Civil-Involuntary Patients)

Special Issues:

Significance: Measuring 30 day readmission rates is a mechanism for gauging the successful reintegration of people returning to the community from state hospitals.

Activities and strategies/ changes/ innovative or exemplary model: To reduce the use of State hospitals by increasing consumers' ability to remain successfully in the community.

Target Achieved or Not Achieved/If Not, Explain Why: The target was achieved; while there were fewer total numbers of discharges in the SFY 06-07, there were also fewer readmissions within 30 days of discharge.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	20.48	22	21.50	25.57	84.08
Numerator	2,343	2,483	--	2,832	--
Denominator	11,443	11,177	--	11,074	--

Table Descriptors:

Goal: To decrease the rate of readmission of adults to State Psychiatric Hospitals within 180 days of discharge

Target: The target for FY 2006-07 was 22%.

Population: Adults with Serious Mental Illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: The percent of adults who are readmitted to State Psychiatric Hospital within 180 days of discharge

Measure: The number of adults readmitted to a State Psychiatric Hospital within 180 days of discharge

Sources of Information: Table 20 A Non-Forensic (Voluntary and Civil-Involuntary Patients)

Special Issues:

Significance: Measuring 180 day readmission rates is a mechanism for gauging the successful reintegration of people returning to the community from state hospitals.

Activities and strategies/ changes/ innovative or exemplary model: To reduce the use of State hospitals by increasing consumers' ability to remain successfully in the community

Target Achieved or Not Achieved/If Not, Explain Why: The target was not achieved; even though the total number of discharges in the year decreased, the number of readmissions within 180 days went up. The resources needed to support community capacity are still being developed.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	1	1	1	1	100
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: To increase the number of Evidence Based Practices for Adults available in North Carolina.

Target: The target is to have a second Evidence Based Practice approved by the Division of Mental Health/Developmental Disabilities/Substance Abuse Services by SFY 2010.

Population: Adults with serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: The number of Evidence Based Practices endorsed by the Division for adults that are being implemented

Measure: The number of Evidence Based Practices meeting Division approval and in actual implementation status

Sources of Information: Developmental Table 16 (as tracked through the Center for Mental Health Services Uniform Reporting System)

Special Issues: Our data system doesn't collect all Evidence Based Practices data as we depend on the service definitions for the data. Assertive Community Treatment Team is currently the service in North Carolina delivered from an Evidence Based Practice platform whose definition has been approved by the Centers for Medicare and Medicaid Services for adults with serious mental illness.

Significance: Evidence Based Practice service models result in improved outcomes for individuals

Activities and strategies/ changes/ innovative or exemplary model: The action plan is to increase the availability of Evidence Based Practices in communities for adults with serious mental illness.

Target Achieved or Not Achieved/If Not, Explain Why: The target was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Number of Persons Receiving Supported Housing (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	0	0	0	0	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal:

Target:

Population: Adults with serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues: North Carolina is not able to track data pertaining to this Evidence Based Practice; we track data via service definitions. However, we are committed to measuring Evidence Based Practices in another fashion. North Carolina will have to formulate a comprehensive, sub-tier manualized way of gathering data that has not yet been developed.

Significance:

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved or Not Achieved/If Not, Explain Why:

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Number of Persons Receiving Supported Employment (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	0	0	0	0	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal:

Target:

Population: Adults with serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues: North Carolina is not able to track data pertaining to this Evidence Based Practice; we track data via service definitions. While North Carolina does have a state funded definition of Supported Employment, it is not Evidence Based Practice focused and when revised, will have to continue to be applicable to the State's other main target populations: people with Developmental Disabilities and Substance Abuse diagnoses. However, we are committed to measuring Evidence Based Practices in another fashion. North Carolina will have to formulate a comprehensive, sub-tier manualized way of gathering data that has not yet been developed.

Significance:

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved or Not Achieved/If Not, Explain Why:

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Number of Persons Receiving Assertive Community Treatment (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	2	2	2	2	100
Numerator	2,657	2,896	--	N/A	--
Denominator	133,353	125,076	--	N/A	--

Table Descriptors:

Goal: To provide Evidence-Based Practices for adults with serious mental illness

Target: The target for FY 2006-07 was that 2% of individuals with serious mental illness served in the community and institutions will receive Assertive Community Treatment services.

Population: Adults with serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: The percent of adults served who have received Evidence-Based Practices, specifically, Assertive Community Treatment Team services.

Measure: The number of adults with serious mental illness who receive the Evidence-Based Practice service of Assertive Community Treatment out of the total number of adults with serious mental illness who receive services from the community and/or institutions (includes Medicaid and non-Medicaid funding).

Sources of Information: Developmental Table 16 (as tracked through the Center for Mental Health Services FY 2004 and 2005 Uniform Reporting System)

Special Issues: The Centers for Medicare and Medicaid Services approved the new enhanced service definition of ACTT in 01/06, with actual implementation beginning on 3/20/06. Our data system doesn't collect all EBP data as we depend on the service definitions for the data. Medicaid funding is included in numbers served above beginning with billings submitted on or after 03/20/06. Specific numbers could not be entered in the table above, but out of 122,563 unduplicated adults served, 2,818 received Assertive Community Treatment.

Significance: Evidence-Based Practice service models result in improved outcomes for individuals.

Activities and strategies/ changes/ innovative or exemplary model: The plan is to increase the availability of Evidence-Based Practices in communities for adults with serious mental illness. North Carolina is attempting to get Medicaid reimbursement for some definitions through which the Evidence-Based Practices could be delivered.

Target Achieved or Not Achieved/If Not, Explain Why: The target was achieved

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Number of Persons Receiving Family Psychoeducation (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	0	0	0	0	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal:

Target:

Population: Adults with serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues: North Carolina is not able to track data pertaining to this Evidence Based Practice; we track data via service definitions. However, we are committed to measuring Evidence Based Practices in another fashion. North Carolina will have to formulate a comprehensive, sub-tier manualized way of gathering data that has not yet been developed.

Significance:

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved or Not Achieved/If Not, Explain Why:

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Number of Persons Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	0	0	0	0	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal:

Target:

Population: Adults with serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues: North Carolina is not able to track data pertaining to this Evidence Based Practice; we track data via service definitions. However, we are committed to measuring Evidence Based Practices in another fashion. North Carolina will have to formulate a comprehensive, sub-tier manualized way of gathering data that has not yet been developed.

Significance:

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved or Not Achieved/If Not, Explain Why:

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Number of Persons Receiving Illness Self-Management (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	0	0	0	0	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal:

Target:

Population: Adults with serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues: North Carolina is not able to track data pertaining to this Evidence Based Practice; we track data via service definitions. However, we are committed to measuring Evidence Based Practices in another fashion. North Carolina will have to formulate a comprehensive, sub-tier manualized way of gathering data that has not yet been developed.

Significance:

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved or Not Achieved/If Not, Explain Why:

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Number of Persons Receiving Medication Management (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	0	0	0	0	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal:

Target:

Population: Adults with serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues: North Carolina is not able to track data pertaining to this Evidence Based Practice; we track data via service definitions. However, we are committed to measuring Evidence Based Practices in another fashion. North Carolina will have to formulate a comprehensive, sub-tier manualized way of gathering data that has not yet been developed.

Significance:

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved or Not Achieved/If Not, Explain Why:

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	92	56	56	55.12	98.43
Numerator	5,787	2,724	--	2,749	--
Denominator	6,286	4,823	--	4,987	--

Table Descriptors:

Goal: To provide community based services that promote positive outcomes

Target: The target for FY 2007 was 56%.

Population: Adults with serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent of adults, served by community based programs who indicate that they had positive outcomes

Measure: The measure is those consumers reporting positively about outcomes.

Sources of Information: North Carolina Consumer Satisfaction Survey

Special Issues: The drop in percentages for this indicator between FY 2005 and FY 2006 came about in large part due to a change in the methodology used in summarizing survey input which, when analyzed and evaluated, resulted in a lower percentage of survey responses from adults who indicated that they had positive outcomes from services received. The decision to go with a different methodology was due to the newly-recommended Federal Guideline issued in late September, 2006.

Significance: Measuring consumer perceptions regarding changes in functioning is an important mechanism for measuring quality.

Activities and strategies/ changes/ innovative or exemplary model: The action plan is to provide effective services that help consumers deal with daily problems and crises when they arise, have better control of their lives, enjoy improved family relations, feel more comfortable in social situations, such as school or work, and realize a decrease in symptoms.

Target Achieved or Not Achieved/If Not, Explain Why: The target was not achieved due to a slight decrease in the number of adults who indicated that they had positive outcomes from the services they received.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Decreased Criminal Justice Involvement

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	12	12	12	12	100
Numerator	0	N/A	--	N/A	--
Denominator	0	N/A	--	N/A	--

Table Descriptors:

Goal: To increase the availability of outreach and services to this population to reduce involvement in the criminal justice system

Target: The target for FY 2007 was to maintain the 12 jail diversion programs around the state.

Population: Adults with serious mental illness

Criterion: 2:Mental Health System Data Epidemiology

Indicator: Number of Local Management Entities that have special Mental Health Block Grant funding to provide jail diversion services

Measure: Number of Local Management Entities providing jail diversion services

Sources of Information: Client Data Warehouse and the jail diversion Consumer Outcomes Indicator data base

Special Issues:

Significance: Assuring that consumers receive the appropriate services in urgent/emergent situations is a major goal of the North Carolina State Plan.

Activities and strategies/ changes/ innovative or exemplary model: The action plan is to reduce the number of adults with serious mental illness who risk being arrested or who are in jails by providing outreach and community-based services.

Target Achieved or Not Achieved/If Not, Explain Why: The target was achieved

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Decreased Use of Adult Admission Bed Days

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	87.09	87	87.21	93.72	94
Numerator	130,443	130,777	--	140,376	--
Denominator	149,775	149,775	--	149,775	--

Table Descriptors:

Goal: To decrease the number of State psychiatric hospital adult admission bed days used

Target: The target for FY 2007 was 87%.

Population: Adults with serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of bed days used for adult admission beds

Measure: Number of bed days used out of total bed days allocated

Sources of Information: Psychiatric Authorized Bed Day Allocation Report

Special Issues: The data submitted in the past to determine hospital utilization was based on the DMH/DD/SAS Bed Day Utilization model. Under this model, certain categories were exempted. For example, bed day utilization was not counted for any patient with the legal status of Incapable to Proceed. Therefore, the model did not account for all bed day utilization at the hospitals. A new model has been developed that will count all bed days utilized. Beginning in FY08, all bed days utilized will be counted.

Significance: A major outcome of the development of a community-based system of care is expected to be reduced utilization of state and county-operated psychiatric inpatient beds.

Activities and strategies/ changes/ innovative or exemplary model: The action plan is to reduce the use of State psychiatric inpatient beds by increasing the capacity of effective services in the community.

Target Achieved or Not Achieved/If Not, Explain Why: The target was not achieved due to an increase in the number of State psychiatric hospital adult admission bed days used.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Decreased Use of Adult Long Term Bed Days

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	74.71	69	69	88	88
Numerator	108,535	100,457	--	106,437	--
Denominator	145,270	145,270	--	120,450	--

Table Descriptors:

Goal: To decrease the number of State psychiatric hospital adult long term bed days used

Target: The target for FY 2007 was 69%.

Population: Adults with serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of bed days used for adult long term beds

Measure: Number of bed days used out of total bed days allocated

Sources of Information: Psychiatric Authorized Bed Day Allocation Report

Special Issues: The data submitted in the past to determine hospital utilization was based on the DMH/DD/SAS Bed Day Utilization model. Under this model, certain categories were exempted. For example, bed day utilization was not counted for any patient with the legal status of Incapable to Proceed. Therefore, the model did not account for all bed day utilization at the hospitals. A new model has been developed that will count all bed days utilized. Beginning in FY08, all bed days utilized will be counted.

Significance: A major outcome of the development of a community-based system of care is expected to be reduced utilization of state and county-operated psychiatric inpatient beds.

Activities and strategies/ changes/ innovative or exemplary model: The action is to reduce the use of State psychiatric inpatient beds by increasing the capacity of effective services in the community.

Target Achieved or Not Achieved/If Not, Explain Why: The target was not achieved, as even though there was a decrease in the total number of bed days allocated, there was an increase in the number of adult long term beds used.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence-Based Practices Trainings

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	28	80	60	61	100
Numerator	0	N/A	--	N/A	--
Denominator	0	N/A	--	N/A	--

Table Descriptors:

Goal: To increase the availability of training regarding evidence-based practices

Target: The target for FY 2007 was to provide at least 60 evidence-based practices trainings.

Population: Adults with serious mental illness

Criterion: 5:Management Systems

Indicator: Number of training events provided regarding the operation of evidence-based practices

Measure: Number of evidence-based trainings

Sources of Information: Reports from the North Carolina Evidence-Based Practice Center, the Behavioral Healthcare Resource Program, the North Carolina Practice Improvement Collaborative, and the Mental Health Systems Transformation Meetings

Special Issues: The NC Evidence-Based Practice Center is supported by its Project Partners which include: the North Carolina Area Health Education Center, Southern Regional Area Health Education Center, and the Division of MH/DD/SA Services. Training is being provided on the following Evidence-Based Practice Toolkits: Assertive Community Treatment Teams, Supported Employment, Family Psycho-Education, Wellness Management and Recovery, and Integrated Dual Disorders Treatment. The Behavioral Healthcare Resource Program from the University of North Carolina at Chapel Hill School of Social Work provides training on Evidence Based Practices, as well as other types of trainings; educational meetings/trainings are also done by the North Carolina Practice Improvement Collaborative, a body of clinicians, consumers, family members and researchers who meet regularly to review evidence based practices. Additionally, there have been trainings for providers via the Mental Health Systems Transformation Grant, through which pilot sites were chosen to develop the infrastructure for Evidence Based Practices.

Significance: Evidence-based practices are proven treatment approaches which have been found to be very successful with individuals with serious mental illness; this is a major part of reforming mental health services, both on a state and national level.

Activities and strategies/ changes/ innovative or exemplary model: The action plan is to increase trainings so that staff can provide effective evidence-based services for adults with serious mental illness, who are frequently in crisis.

Target Achieved or Not Achieved/If Not, Explain Why: The target was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Increased Access to Services

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	94	76	76	77	100
Numerator	5,880	3,742	--	3,889	--
Denominator	6,231	4,901	--	5,052	--

Table Descriptors:

Goal: To provide community based services that are accessible to consumers

Target: The target for FY 2006-07 was 76%.

Population: Adults with serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of adults served by community based programs who indicated that they "agreed" or "strongly agreed" that they had good access to services

Measure: The number of consumers responding to the North Carolina Consumer Satisfaction Survey

Sources of Information: North Carolina Consumer Satisfaction Survey

Special Issues: Late in November, 2006, the State Planners learned that in an effort to better align North Carolina's data information and implementation reporting process with federal and state protocols, North Carolina's quality management system was revised. The Planners submitted modifications to the North Carolina Community Mental Health Services Block Grant Plan for SFY 2006-07. Thus, as of November 2006, the methodology used in North Carolina for summarizing the input from the North Carolina Consumer Satisfaction Survey changed to one with a more aggressive approach toward data validity. Therefore, the survey done in October, 2006, also reflects the application of the changed methodology. This changed methodology resulted in a lower percentage of survey responses from adults who indicated that they either agreed or strongly agreed that they had good access to services.

Significance: Assuring access to services for adults with a serious mental illness is a National Outcome Measure and critical component of successful service transformation.

Activities and strategies/ changes/ innovative or exemplary model: The activity plan is to provide services in convenient locations and times, that are staffed so that consumers are seen as needed, that service requests are responded to in a timely manner, and that all of the needed services can be obtained.

Target Achieved or Not Achieved/If Not, Explain Why: The target was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Increased Service Access by Older Adults

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	20	20	20	20	100
Numerator	0	N/A	--	N/A	--
Denominator	0	N/A	--	N/A	--

Table Descriptors:

Goal: To enable older adults who have severe mental illness to live safely in the community and to have access to appropriate care and mental health treatment.

Target: The target for FY 2007 was to maintain the 20 Mental Health/Adult Geriatric Specialty Teams.

Population: Older adults with serious mental illness

Criterion: 2:Mental Health System Data Epidemiology

Indicator: Number of Mental Health/Adult Geriatric Specialty Teams providing consultative services to programs serving older adults and younger people with mental illness.

Measure: The total number or count of Mental Health/Adult Geriatric Specialty Teams

Sources of Information: Money is allocated to fund Mental Health/Adult Geriatric Specialty Teams and providers who deliver this service are responsible for providing the information.

Special Issues: The Teams do not provide direct services to individuals residing at the different facilities, homes, or agencies, but do provide consultation to the staff and caregivers of the individuals.

Significance: As baby boomers age and the number of older adults with serious mental illness increases, the need for access to services is a critical component of mental health reform.

Activities and strategies/ changes/ innovative or exemplary model: The action plan is to develop and maintain Mental Health/Adult Geriatric Specialty Teams to educate and consult with community based facilities that are serving older adults and younger adults (in these same facilities) with serious mental illness.

Target Achieved or Not Achieved/If Not, Explain Why: The target was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Maintenance of Services

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	54,633,991	54,480,145	57,588,829	67,627,685	100
Numerator	0	N/A	--	N/A	--
Denominator	0	N/A	--	N/A	--

Table Descriptors:

Goal: To utilize available funds to support community based programs

Target: The target for FY 2007 was the projected spending of $57,588,829.00 to maintain services.

Population: Adults with serious mental illness

Criterion: 5:Management Systems

Indicator: Funds to maintain services

Measure: State and Federal funding allocated

Sources of Information: The Division of Mental Health/Developmental Disabilities/Substance Abuse Services' Preliminary Continuation Allocation letters are the sources for this information

Special Issues: Data are based on allocations, not expenditures. The data do not reflect any subsequent allocation of funds during the year.

Significance: This funding helps provide continued maintenance of services for adults with serious mental illness.

Activities and strategies/ changes/ innovative or exemplary model: The action plan is to support community based services for adults with serious mental illness, using state and federal funding.

Target Achieved or Not Achieved/If Not, Explain Why: The target was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Satisfaction with Care

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	92	89	89	91	100
Numerator	5,596	4,407	--	4,620	--
Denominator	6,067	4,939	--	5,084	--

Table Descriptors:

Goal: To provide community-based services that are responsive to consumers' needs and preferences

Target: The target for FY 2007 was 89%.

Population: Adults with serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percent of adults served by community based programs who indicated that they were satisfied with the services provided.

Measure: Number of consumers responding to the North Carolina Consumer Satisfaction Survey

Sources of Information: North Carolina Consumer Satisfaction Survey

Special Issues: Late in November, 2006, the State Planners learned that in an effort to better align North Carolina's data information and implementation reporting process with federal and state protocols, North Carolina's quality management system was being revised. The Planners submitted modifications to the North Carolina Community Mental Health Services Block Grant Plan for SFY 2006-07. Thus, as of November 2006, the methodology used in North Carolina for summarizing the input from the North Carolina Consumer Satisfaction Survey changed to one with a more aggressive approach toward data validity. Therefore, the survey done in October, 2006, also reflects the application of the changed methodology. This changed methodology resulted in a lower percentage of survey responses from adults who indicated that they either agreed or strongly agreed that they were satisfied with the services they received.

Significance: Measuring consumer satisfaction with services is a mechanism for measuring quality.

Activities and strategies/ changes/ innovative or exemplary model: The action plan is to provide services in a way that is satisfying to consumers so that they like the services they receive, would continue to choose the provider agency, and would recommend the agency to others.

Target Achieved or Not Achieved/If Not, Explain Why: The target was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Services for Adults Who Are Homeless

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	2,043	3,246	3,300	5,389	100
Numerator	0	N/A	--	N/A	--
Denominator	0	N/A	--	N/A	--

Table Descriptors:

Goal: To provide outreach and services to people who are homeless

Target: The target for FY 2007 was to serve 3300 persons.

Population: Adults with serious mental illness

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: Number of homeless persons who receive mental health services supported by Programs for Assistance in Transition from Homelessness (PATH)funding.

Measure: The Outreach Performance Indicator refers to the number of individuals provided with outreach by PATH staff.

Sources of Information: Projects for Assistance in Transition from Homelessness Grant award.

Special Issues: The SFY 06-07 numbers for outreach increased due to PATH positions being fully staffed, technical assistance that was provided by the Division of MH/DD/SAS PATH Specialist, and training opportunities from the State, as well as outreach training.

Significance: Addressing the need for homeless adults with serious mental illness to engage in services enables this growing population to improve their quality of life.

Activities and strategies/ changes/ innovative or exemplary model: The activity plan is to enable homeless adults with serious mental illness to engage in mental health services and to obtain safe, affordable housing.

Target Achieved or Not Achieved/If Not, Explain Why: The target was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Services for Persons in Rural Areas

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	549	462	462	444	96
Numerator	0	N/A	--	N/A	--
Denominator	0	N/A	--	N/A	--

Table Descriptors:

Goal: To ensure that rural residents have equitable access to services

Target: The target for FY 2007 was that 462 persons per 10,000 population will be served.

Population: Adults with serious mental illness

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: Rates served per 10,000 population in rural areas

Measure: Numbers of adults served in area programs by county and categorized into rural areas compared to general population rates

Sources of Information: NC Area Programs Annual Statistics and Admissions Report, Fiscal Year 2007

Special Issues: The persons served data in SFY 2006 and SFY 2007 is for adults who received services from the public MH/DD/SA system (except for those individuals from out of State and individuals for whom no county of service information was reported). Previous years reflect numbers of combined children and adults served in rural areas.

Significance: Providing services to adult residents in communities of their choice is the primary focus of the redesigned mental health system.

Activities and strategies/ changes/ innovative or exemplary model: The activity or strategy plan is to provide rural residents with equitable access to services by reducing barriers to service in those areas.

Target Achieved or Not Achieved/If Not, Explain Why: The target was not achieved due to a slight decrease in the numbers of rural residents served.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Services for Persons in Urban Areas

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	361	352	352	335	95
Numerator	0	N/A	--	N/A	--
Denominator	0	N/A	--	N/A	--

Table Descriptors:

Goal: To ensure that residents have equitable access to services

Target: The target for FY 2007 was that 352 persons per 10,000 population would be served.

Population: Adults with serious mental illness

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: Rates served per 10,000 population in urban areas

Measure: Numbers of adults served in area programs by county and categorized into urban areas compared to general population rates

Sources of Information: NC Area Programs Annual Statistics and Admissions Report, Fiscal Year 2007

Special Issues: The persons served data in SFY 2006 and SFY 2007 is for adults who received services from the public MH/DD/SA system (except for those individuals from out of State and individuals for whom no county of service information was reported). Previous years reflect numbers of combined children and adults served in urban areas.

Significance: Providing services to adult residents in communities of their choice is the primary focus of the redesigned mental health system.

Activities and strategies/ changes/ innovative or exemplary model: The activity or strategy plan is to provide urban residents with equitable access to services in those areas.

Target Achieved or Not Achieved/If Not, Explain Why: The target was not achieved due to a slight decrease in numbers of adults served in urban areas.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Training Events for Mental Health Providers

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	28	104	40	184	100
Numerator	0	N/A	--	N/A	--
Denominator	0	N/A	--	N/A	--

Table Descriptors:

Goal: To increase the ability of the workforce to do best practices and individualized person-centered planning

Target: The target for FY 2007 was that there will be at least 40 trainings.

Population: Adults with serious mental illness

Criterion: 5:Management Systems

Indicator: Number of training events designed for sservice providers

Measure: Number of training events to help address the needs of adults with serious mental illness

Sources of Information: Behavioral Healthcare Resource Program of the University of North Carolina at Chapel Hill School of Social Work Training Report (SFY 2007)

Special Issues: This indicator includes trainings on best practices, person-centered planning, and the new approved service definitions (service definition training may not be recurring on an annual basis). In past years, this indicator has included the evidence-based practice trainings as well, but to differentiate between types of trainings, only those trainings other than evidence-based trainings measures are included in this indicator. Evidence-based trainings measures are shown in another table.

Significance: North Carolina has adopted seeveral goals from the 2003 President's New Freedom Commission on Mental Health and one of them focuses on improving and expanding the workforce. One means of accomplishing this is to train providers in service delivery that helps people reach their goals on their journey to recovery and self-determination.

Activities and strategies/ changes/ innovative or exemplary model: The action plan is to make best practices and person-centered training available to service providers and managers.

Target Achieved or Not Achieved/If Not, Explain Why: The target was achieved.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	72,076	68,227	65,000	65,795	101.22
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: To provide community based services which are accessible to children and families

Target: The target for FY 2007 was 65,000.

Population: Children with serious emotional disturbance

Criterion: 2:Mental Health System Data Epidemiology
3:Children's Services

Indicator: The number of children and adolescents with serious emotional disturbance who received community based services and supports.

Measure: Number of children and adolescents served through funding by the state mental health agency

Sources of Information: Core indicator #1 Increased Access to Services (Table 2A)

Special Issues: System changes in LME and provider role and functions have impacted access for those with most serious needs. Modifications to the service flow and provider endorsement and enrollment process will be made to improve access. Consumer education will be an ongoing strategy to promote access.

Significance: Assuring access to services for children with serious emotional disturbance is a primary goal of the mental health block grant legislation and state plan transformation

Activities and strategies/ changes/ innovative or exemplary model: The activity or strategy plan is to provide services that are in convenient locations and at convenient times, that are staffed so that consumers are seen as often as necessary, that requests for service are responded to in a timely manner, and that all needed services can be obtained.

Target Achieved or Not Achieved/If Not, Explain Why: The target was achieved.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	9.60	11	10	11.96	83.61
Numerator	140	175	--	202	--
Denominator	1,458	1,522	--	1,689	--

Table Descriptors:

Goal: To decrease the rate of readmission of children and adolescents to State Psychiatric Hospitals within 30 days of discharge

Target: The target for FY 2007 was 10%.

Population: Children with serious emotional disturbance

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent of children and adolescents who are readmitted to State Psychiatric Hospitals within 30 days of discharge

Measure: Number of children who are readmitted to State Psychiatric Hospitals within 30 days of discharge

Sources of Information: Core indicator #2 Reduced Utilization of Psychiatric Inpatient Beds (Table 20A)

Special Issues: The target attained percent reflects the ratio of the increase in numerator and denominator proportionately from FY04 to FY05. Efforts have continued to provide the community based services and supports that will enable children to return to their families/communities without requiring readmission.

Significance: Measuring 30 day readmission rates is a mechanism for gauging the successful reintegration of people returning to the community from state hospitals

Activities and strategies/ changes/ innovative or exemplary model: The activity or strategy plan is to reduce the use of State hospitals by increasing consumers' ability to remain successfully in the community.

Target Achieved or Not Achieved/If Not, Explain Why: The target was not achieved as total bed days went up as well as the number of readmissions within 30 days.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	17.50	18	15	21.73	69.03
Numerator	255	283	--	367	--
Denominator	1,458	1,522	--	1,689	--

Table Descriptors:

Goal: To decrease rate of readmission of children and adolescents to State Psychiatric Hospitals within 180 days of discharge

Target: The target for FY 2007 was 15%.

Population: Children with serious emotional disturbance

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent of children and adolescents who are readmitted to State Psychiatric Hospitals within 180 days of discharge

Measure: Number of children and adolescents who are readmitted to State Psychiatric Hospitals within 180 days of discharge

Sources of Information: Core indicator #2 Reduced Utilization of Psychiatric Inpatient Beds (Table 20A)

Special Issues: The target attained percent reflects the ratio of the increase in numerator and denominator proportionately from FY04 to FY05. Efforts have continued to provide the community based services and supports that will enable children to return to their families/communities without requiring readmission.

Significance: Measuring 180 day readmission rates is a mechanism for gauging the successful reintegration of people returning to the community from state hospitals.

Activities and strategies/ changes/ innovative or exemplary model: The activity plan is to reduce the use of State hospitals by increasing consumers' ability to remain successfully in the community.

Target Achieved or Not Achieved/If Not, Explain Why: The target was not achieved due to an increase in the number of total discharges as well as an increase in the number of readmissions within 180 days.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	N/A	N/A	2	2	100
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: To increase the number of Evidence Based Practices for children and adolescents available in North Carolina

Target: The target was to have 2 Evidence Based Practices by SFY 2007.

Population: Children with serious emotional disturbance

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: The number of Evidence Based Practices endorsed by the Division for children that are being implemented (specifically Therapeutic Foster Care and Multi-Systemic Therapy)

Measure: The number of Evidence Based Practices meeting Division approval and in actual implementation status (specifically, Therapeutic Foster Care and Multi-Systemic Therapy)

Sources of Information: Developmental Table 16 (as tracked through the Center for Mental Health Services Uniform Reporting System)

Special Issues: Our data system doesn't collect all Evidence Based Practice data as we depend on the service definitions for the data.

Significance: Evidence Based Practice service models result in improved outcomes for individuals

Activities and strategies/ changes/ innovative or exemplary model: The activity plan is to increase the availability of Evidence Based Practices in communities for children with serious emotional disturbance.

Target Achieved or Not Achieved/If Not, Explain Why: The target was achieved.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Number of Persons Receiving Therapeutic Foster Care (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	2,151	2,368	2,188	2,673	122.17
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: To provide Evidence-Based Practices for children and adolescents with or at risk for serious emotional disturbance

Target: The target for FY 2007 was 2188.

Population: Children with serious emotional disturbance

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of children and adolescents served who have received Evidence-Bassed Practice. Out of 38,560 children and youth, 2673 received Therapeutic Foster Care in FY 2007.

Measure: Number of children and adolescents who are receiving Evidence-Based Practice services, specifically Therapeutic Foster Care.

Sources of Information: Developmental Table 16 (as tracked through the Center for Mental Health Services FY 2007 Uniform Reporting System)

Special Issues: North Carolina is attempting to get Medicaid reimbursement for some definitions through which the Evidence-Based Practices could be delivered; we are waiting for the Centers for Medicare and Medicaid approval. Our data system doesn't collect all Evidence-Based Practice data as we depend on the service definitions for the data. Medicaid funding is not included in the numbers served in the data table and that is a major source of funding for many of these Evidence-Based Practices.

Significance: Evidence-Based Practice service models result in improved outcomes for individuals.

Activities and strategies/ changes/ innovative or exemplary model: The activity plan is to increase the availability of Evidence-Based Practices in communities for children and adolescents and as stated above, to continue to try to get Medicaid reimbursement for definitions through which these Practices could be delivered.

Target Achieved or Not Achieved/If Not, Explain Why: The target was achieved.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Number of Persons Receiving Multi-Systemic Therapy (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	N/A	74	40	293	732.50
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: To provide Evidence Based Practices for children and adolescents with or at risk for serious emotional disturbance.

Target: The target for FY 2007 was 40.

Population: Children with serious emotional disturbance

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of children and adolescents served who have received the Evidence Based Practice of Multi-Systemic Therapy.

Measure: Number of children and adolescents served who are receiving Multi-Systemic Therapy

Sources of Information: Developmental Table 16 (as tracked through the Center for Mental Health Services FY 2007 Uniform Reporting System)

Special Issues: Multi-Systemic Therapy was implemented in our State in March, 2006, so there was no data available for this service in FY 2005. North Carolina continues to pursue Medicaid reimbursement for some definitions through which the Evidence-Based Practices could be delivered; we continue to work with the Division of Medical Assistance and the Centers for Medicare and Medicaid toward this end. Our data system doesn't collect all Evidence-Based Practice data as we depend on the service definitions for the data. Medicaid funding is not included in the numbers served in the data table and that is a major source of funding for many of these Evidence Based Practices.

Significance: Evidence Based Practice service models result in improved outcomes for individuals.

Activities and strategies/ changes/ innovative or exemplary model: The activity plan is to maintain current Evidence Based Practices and increase the availability of others in communities for children and adolescents and as stated above, to continue to try to get Medicaid and Health Choice reimbursement for definitions through which these Practices can be delivered.

Target Achieved or Not Achieved/If Not, Explain Why: The target was achieved.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Number of Persons Receiving Family Functional Therapy (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues: North Carolina currently does not track this Evidence Based Practice.

Significance:

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved or Not Achieved/If Not, Explain Why:

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	93	64	64	66.37	103.70
Numerator	2,472	1,380	--	1,409	--
Denominator	2,650	2,142	--	2,123	--

Table Descriptors:

Goal: To increase the percentage of children with Serious Emotional Disturbance for whom there are positive changes in functioning

Target: The target for FY 2007 was 64%.

Population: Children with Serious Emotional Disturbance

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of children with Serious Emotional Disturbance for whom there are positive changes in functioning

Measure: Number of consumers responding to the NC Consumer Satisfaction Survey

Sources of Information: NC Consumer Satisfaction Survey

Special Issues: Future mergers and consolidations of area authorities/county programs into Local Management Entities (LMEs) may have an impact on consumer responses. Also, as of November, 2006, the methodology used in North Carolina for summarizing the input from the NC Consumer Satisfaction Survey changed to one with a more aggressive approach toward data validity. This changed methodology resulted in a lower percentage of survey responses from consumers who indicated that they either agreed or strongly agreed that they felt positively about their service outcomes. There was not a definitive way of predicting how the transformation changes would actually impact people's perceptions around service access/delivery.

Significance: Assuring that children with serious emotional disturbance and their families feel positively about their service outcomes is a primary goal of the mental health block grant legislation and the state plan's transformation foundation of person centered planning/child and family centered team planning.

Activities and strategies/ changes/ innovative or exemplary model: The activity plan is to provide community-based services which promote positive outcomes.

Target Achieved or Not Achieved/If Not, Explain Why: The target was achieved.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Access to Services

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	86	79	75	81	100
Numerator	2,225	1,705	--	1,698	--
Denominator	2,586	2,150	--	2,105	--

Table Descriptors:

Goal: To provide community based services which are accessible to children and families

Target: The target for FY 2007 was 75%.

Population: children with serious emotional disturbance

Criterion: 2:Mental Health System Data Epidemiology
3:Children's Services

Indicator: Percentage of families of children, served by community based programs, who indicated on the Consumer Satisfaction Survey that they had good access to services

Measure: Number of consumers responding to the NC Consumer Satisfaction Survey

Sources of Information: North Carolina Consumer Satisfaction Survey

Special Issues: As of November 2006, the methodology used in North Carolina for summarizing the input from the NC Consumer Satisfaction Survey changed to one with a more aggressive approach toward data validity. Thus, the survey done in October 2006 reflects the application of the changed methodology. This changed methodology resulted in a lower percentage of survey responses from consumers who indicated that they either agreed or strongly agreed that they had good access to services.

Significance: Assuring access to services for children with serious emotional disturbance is a primary goal of the Mental Health Block Grant legislation and state plan transformation.

Activities and strategies/ changes/ innovative or exemplary model: The activity plan is to provide services that are in convenient locations and at convenient times, that are staffed so that consumers are seen as often as necessary, that requests for service are responded to in a timely manner, and that all needed services can be obtained.

Target Achieved or Not Achieved/If Not, Explain Why: The target was achieved.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Appropriateness of Care

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	91	81	75	83	100
Numerator	2,356	1,765	--	1,778	--
Denominator	2,586	2,178	--	2,144	--

Table Descriptors:

Goal: To provide community-based services that are responsive to consumers' needs and preferences

Target: The target for FY 2007 was 75%.

Population: Children with Serious Emotional Disturbance

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of children with serious emotional disturbance or their parents receiving services who rate appropriateness of care positively

Measure: Number of consumers responding to the NC Consumer Satisfaction Survey

Sources of Information: NC Consumer Satisfaction Survey

Special Issues: As of November 2006, the methodology used in North Carolina for summarizing the input from the NC Consumer Satisfaction Survey changed to one with a more aggressive approach toward data validity. This changed methodology resulted in a lower percentage of survey responses from consumers who indicated that they either agreed or strongly agreed that they would rate their appropriateness of care positively. There was not a definitive way of predicting how the transformation changes would actually impact people's perceptions around service access/delivery. Also, mergers and consolidations of area authorities/county programs into Local Management Entities (LMEs) may have an impact on consumer responses.

Significance: Assuring appropriateness of care for children with serious emotional disturbance and their families is a primary goal of the mental health block grant legislation and the state plan's transformation foundation of person centered planning/child and family centered team planning.

Activities and strategies/ changes/ innovative or exemplary model: The activity plan is to maintain the percentage of children with Serious Emotional Disturbance or their parents receiving services who rate appropriateness of care positively.

Target Achieved or Not Achieved/If Not, Explain Why: The target was achieved.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Collaboration

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	30	28	25	29	100
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: To increase collaboration among child-serving agencies

Target: The target for FY 2007 is 28.

Population: Children with Serious Emotional Disturbance

Criterion: 3:Children's Services

Indicator: Number of local community programs with established Local Community Collaboratives

Measure: Number of community programs/Local Management Entities (LMEs) reporting an established community collaborative and signed Memorandum of Agreement

Sources of Information: Local Management Entity survey and performance agreement

Special Issues: Each Local Management Entity (LME) has a Community Collaborative. As the number of LMEs decreases, there will be a decrease in the number of Community Collaboratives.

Significance: Collaboration is a cornerstone of the child plan and state plan implementation and a requirement for demonstrating effective practice and good resource management of federal and state block grant funds. No one resource or agency can meet consumers' needs. A tenant of System of Care (SOC) is its effective partnership at all levels with families and other stakeholders essential to improving outcomes for children and their families.

Activities and strategies/ changes/ innovative or exemplary model: The action plan is to increase collaboration among local community based programs, Departments of Social Services, the Department of Juvenile Justice and Delinquency Preventiion and the Department of Public Instruction around serving at-risk children.

Target Achieved or Not Achieved/If Not, Explain Why: Target Achieved - More than 57 community collaboratives exist in our state meeting on average monthly, with 29 of 30 LMEs completing signed MOAs as of June 30, 2007.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence-Based Practice Trainings

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	17	19	15	30	100
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: To promote the adoption of effective evidence based practices for children and adolescent mental health services

Target: The target for FY 2007 was that 15 evidence based practice trainings would be held.

Population: Children with serious emotional disturbance

Criterion: 5:Management Systems

Indicator: Number of training events provided regarding the implementation of evidence-based practices, specifically for child and adolescent mental health services, service providers and families.

Measure: Number of trainings made available

Sources of Information: Reports from the NC Area Health Education Centers, Universities, NC Council of Community Programs, Public Health and Primary Care, Family Advocate, LME and provider agency training calendars, DMH/DD/SAS reports and Learning Community calendar.

Special Issues: Trainings offered often include parent co-presenters regarding the Person-Centered Planning tenants and System of Care principles. Topics have included trauma-based treatments, treatment approaches in outpatient/therapeutic counseling such as cognitive behavioral therapy and parent child interaction therapy (PCIT), MST (Multi-Systemic Therapy), intensive in-home models. The indicator measure is the number of evidence-based and promising practice training events designed specifically for service providers regarding services for child, adolescent, and family mental health services.

Significance: Evidence-based practices are proven treatment approaches which have been found to be very successful with children with or at risk for serious emotional disturbance and complex or co-occurring disorders. Workforce development is an essential component of this system transformation.

Activities and strategies/ changes/ innovative or exemplary model: The action plan is to make evidence based practices available to service providers and managers.

Target Achieved or Not Achieved/If Not, Explain Why: Target Achieved

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Family Information Sharing and Education

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	19	21	15	29	100
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: To make training and support available to consumers and families

Target: The target for FY 2007 was that 15 trainings and educational events would be provided for children and families.

Population: Children with serious emotional disturbance

Criterion: 5:Management Systems

Indicator: Trainings and educational events specifically designed for consumers and families

Measure: Number of formal training events designed specifically for consumers or family members

Sources of Information: Please refer to section below

Special Issues: Information comes from family advocate organization & training reports; training calendars from NC AHECs, Universities, NC Council of Community Programs, Public Health & Primary Care, Family Advocate, LME & provider training calendars, the DMH/DD/SAS reports & Learning Community calendars & members of the State Collaborative for Children and Families. Also, trainings offered may include parent co-presenters regarding the Person-Centered Planning tenants and System of Care principles. Topics have included trauma-based treatments, treatment approaches in outpatient/therapeutic counseling such as cognitive behavioral therapy and parent child interaction therapy (PCIT), MST (Multi-Systemic Therapy), intensive in-home models.

Significance: Family members and youth consumers need to be informed consumers, supported with education and resource information upon which to become better self-and-peer advocates and change agents serving as advisors, policymakers, partners in multiple levels and leaders. The state and federal system transformation is founded on consumer involvement, education, and support.

Activities and strategies/ changes/ innovative or exemplary model: The action plan is to provide opportunities for families to obtain information and training about best practice service innovations for children and adolescents.

Target Achieved or Not Achieved/If Not, Explain Why: Taregt Acheived

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Juvenile Justice Involvement

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	8.30	21.86	22	16.70	17
Numerator	24	457	--	869	--
Denominator	289	2,091	--	5,213	--

Table Descriptors:

Goal: To reduce involvement in the juvenile justice system for children and adolescents with Serious Emotional Disturbance

Target: The target for FY 2007 was 22

Population: Children with Serious Emotional Disturbance

Criterion: 3:Children's Services

Indicator: Percentage of children with Serious Emotional Disturbance who are receiving treatment at three months after admission who are also clients of the juvenile justice system.

Measure: Number of children with Serious Emotional Disturbance who are involved with juvenile justice

Sources of Information: NC Treatment Outcomes and Program Performance System (NC-TOPPS)

Special Issues: Mergers and consolidations of area authorities/county programs into Local Management Entities (LMEs) may have impacted consumer responses. Also, about 8.3% of children and adolescents with most Serious Emotional Disturbance had been in trouble with the law within the past three months for whom a NCTOPPS assessment was completed at the 6 month interval in SFY 04-05. The samples for previous years, however, consisted of children and adolescents at various levels of need who were admitted into the system and who completed the initial MH/SA Client Outcome Inventory (COI)form.

The current sample consists of those children with or at risk for most Serious Emotional Disturbances who were receiving treatment at 3 months after admission and for where NC TOPPS was completed. The sample size has increased as the NCTOPPS is implemented more fully with those chidlren served. The methodology has improved and is now more consistent using a matched sample.

Significance: Person centered/child and family team planning requires coordinated team planning to work toward common treatment and program goals that promote positive outcomes for children and their families, especially those in or at risk of entering the juvenile justice system and need mental health treatment.

Activities and strategies/ changes/ innovative or exemplary model: The action plan is to assess the number of children with Serious Emotional Disturbance who have been in trouble with the law within the past three months.

Target Achieved or Target not achieved - The methodology is still changing in use and compliance with

Not Achieved/If Not, Explain Why:	NCTOPPS. While we are moving toward using a matched sample and a lareger sample of children, fewer NCTOPPS were completed on the total number of children who were in treatment at 3 months interval but for whom treatment was provided while involved in the justice system. This will need to be sddressed 1) through coordinated effort with the MAJORS universal mental health and substance abuse completed as children/adolescents first interface with juvenile justice and enter treatment, and improved compliance by reporting such outcomes by communities/providers reporting NCTOPPS data.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: School Enrollment

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	90.90	89.06	85	92	100
Numerator	220	1,181	--	4,801	--
Denominator	242	1,326	--	5,213	--

Table Descriptors:

Goal: To increase educational outcomes for children and adolescents with or at risk for serious emotional disturbance

Target: The target for FY 2007 was 85.

Population: Children with Serious Emotional Disturbance

Criterion: 3:Children's Services

Indicator: Percentage of children and adolescents with Serious Emotional Disturbance who are enrolled in school or have a GED

Measure: Number of children and adolescents who are enrolled in school or have a GED

Sources of Information: North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS)

Special Issues: Mergers and consolidations of area authorities/county programs into Local Management Entities (LMEs) may have impacted consumer responses. Also, the current sample in the table is restricted to children with most Serious Emotional Disturbances who were in treatment three months after initial assessment. Despite the severity of their illnesses, a large proportion of children and adolescents with most Serious Emotional Disturbances who completed NC TOPPS, were still attending school, or had obtained a diploma or GED at three months. The sample size has increased as the NCTOPPS is implemented more fully with those chidlren served. The methodology has improved and is now more consistent using a matched sample.

Significance: Person centered/child and family team planning requires coordinated team planning to work toward common treatment and program goals that promote positive outcomes for children and their families, especially those in or at risk of suspension, expulsion or drop out and need mental health treatment.

Activities and strategies/ changes/ innovative or exemplary model: The action plan is to maintain or increase school attendance of children and adolescents with or at risk for serious emotional disturbance.

Target Achieved or Not Achieved/If Not, Explain Why: Target Achieved

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Services for Children who are homeless

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	150,000	15,000	50,000	50,000	100
Numerator	0	N/A	--	N/A	--
Denominator	0	N/A	--	N/A	--

Table Descriptors:

Goal: To maintain the amount of PATH (Programs for Assistance in Transition from Homelessness) funding to programs serving children and adolescents

Target: The target for FY 2007 was to maintain the funding level of $50,000.

Population: Children with Serious Emotional Disturbance

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: Amount of PATH funding for programs serving children and adolescents

Measure: Count of homeless persons who receive mental health services supported by special programs such as Programs for Assistance in Transition from Homelessness

Sources of Information: Annual PATH Report

Special Issues: Sustaining children's PATH services remains a challenge in communities due to the organizational developmental transition the LMEs are experiencing. The target is estimated to be lower during the next FY (2007) due to the observed trend of increasing access to the larger community network of services, especially in schools where McKinney Vento Act homeless coordinators are working to impact these youths' needs.

Significance: PATH programs have provided a mechanism to increase service provision to children with serious emotional disturbance who are homeless.

Activities and strategies/ changes/ innovative or exemplary model: The action plan is to provide outreach to and enable children with Serious Emotional Disturbance who are homeless to engage in community-based mental health services.

Target Achieved or Not Achieved/If Not, Explain Why: Target Achieved

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Services in rural areas

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	549	453	450	415	92
Numerator	0	N/A	--	N/A	--
Denominator	0	N/A	--	N/A	--

Table Descriptors:

Goal: To reduce barriers to service in rural areas

Target: The target for FY 2007 was that 450 children (between the ages of birth-17 years) per 10,000 population will be served.

Population: Children with serious emotional disturbance

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: Rates served per 10,000 population in rural areas

Measure: Number of persons served per 10,000 population in rural areas

Sources of Information: NC Local Management Entity (LME)/Area Programs Annual Statistics and Admissions Report, SFY 2007

Special Issues: The persons served data for all individuals who received services from the public MH/DD/SA system except for those individuals from out of State and individuals for whom no county of service information was reported. Also, beginning in FY 06, only children between birth and 17 years of age are reported per 10,000. Previous years reflect numbers of combined children and adults served in rural areas.

Significance: Providing services to residents in communities of their choice is the primary focus of the redesigned mental health system. System design must consider the diversity of needs and cultural competence of the transformed system for consumers who live in rural areas of the state.

Activities and strategies/ changes/ innovative or exemplary model: The action plan is to ensure that rural residents have equitable access to services.

Target Achieved or Not Achieved/If Not, Explain Why: The target was not achieved as there was a slight decrease in the numbers of children served in rural areas.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Services in urban areas

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2007 Percentage Attained
Performance Indicator	361	336	336	321	96
Numerator	0	N/A	--	N/A	--
Denominator	0	N/A	--	N/A	--

Table Descriptors:

Goal: To reduce barriers to service in urban areas

Target: The target for FY 2007 was that 336 children (between the ages of birth-17 years) per 10,000 population would be served.

Population: Children with serious emotional disturbance

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: Rates served per 10,000 population in urban areas

Measure: Number of persons served per 10,000 population in urban areas

Sources of Information: NC Local Management Entity (LME)/Area Programs Annual Statistics and Admissions Report, SFY 2007

Special Issues: The persons served data for all individuals who received services from the public MH/DD/SA system except for those individuals from out of State and individuals for whom no county of service information was reported. Also, beginning in FY 06, only children between birth and 17 years of age are reported per 10,000. Previous years reflect numbers of combined children and adults served in urban areas.

Significance: Providing services to residents in communities of their choice is the primary focus of the redesigned mental health system. System design must consider the diversity of needs and cultural competence of the transformed system for consumers who live in urban areas of the state.

Activities and strategies/ changes/ innovative or exemplary model: The action plan is to ensure that urban residents have equitable access to services.

Target Achieved or Not Achieved/If Not, Explain Why: The target was not achieved due to a slight decrease in the numbers of children served in urban areas.

North Carolina

Planning Council Letter for the Implementation Report

Upload Planning Council Letter for the Implementation Report

North Carolina
Mental Health Planning and Advisory Council

November 21, 2007

Ms. LouEllen M. Rice
Grants Management Officer
Division of Grants Management, OPS
SAMHSA
1 Choke Cherry Road
Room 7-1091
Rockville, Maryland 20850

Dear Ms. Rice:

On behalf of the North Carolina Mental Health Planning and Advisory Council, I am pleased to write this letter of endorsement and offer recommendations to the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MHDDSA) resulting from our work as a Council in preparing and reviewing the MH BG Implementation Report toward achieving the outlined national outcomes measures submitted for FFY 06 -07

Our Council has engaged in numerous activities this past year, which would include:

- Working with the NC Division of MH/DD/SAS in identifying funding for Council iniative in holding focus groups in community regions across the state
- Reviewing data tables related to Indicators, Targets, and Action Plans
- Reviewing National Outcome Measures
- Reviewing the functioning of NC TOPPS (Treatment Outcomes and Program Performance System). NC TOPPS is used by the NC Division of MH/DD/SAS as a way to capture consumer outcomes.
- Supporting the passage of mental health parity legislation by the NC Senate and House of Representatives

While strengths of the transforming system are built on best practices and consumer empowerment and/or family-driven, it is clear to us that the North Carolina Division of MH/DD/SAS and its interagency partners must remain focused on the following:

For Children, Adolescents, Youth in Transition and Their Families:

- Continue to build an evaluation system that is outcomes driven for services provided to every child, youth, and family
- Establish policy and a sustaining mechanism to reimburse family/youth for time and travel required to fully participate as leaders and partners across all levels of system transformation
- Establish and fund value added services such as peer support specialists for children, youth and families
- Examine and report strengths and challenges of recent legislative action to implement 'single stream' funding in several Local Management Entities (LMEs). In particular, study and report on the impact of the abiity to engage the community in public forums to establish local business priorities, sustain and grow services for children, youth and family and also invest in funding family support practices in these LME communities in the next year and over time, if such funding continues
- Continue to link consumers, youth and families and coordinate formal services with informal supports to improve outcomes
- Address barriers to workforce development for mental health and substance abuse services, especially in underserved areas in the state
- There needs to be increase consumer, youth and family voice in the state

For Adult Consumers:

- To increase education/training for consumer and family members, as well as for providers/direct care/support staff
- To support the development of EBPs that focus on jail diversion, after care practices on post incarceration basis, services to older adults with mental illness, and services that support Peer Specialists.
- To increase the number of safe, affordable housing options for people with mental illness
- To increase systematic support for the concepts of recovery across the whole service delivery system

In Summary, North Carolina has taken some of the following steps to transfom our system of care:

- Develop crisis response units around the State to ensure every county has access to a crisis portal of entry for individuals/familiesin crisis
- Continued transition of service delivery from the local area MH/DD/SAS authorities to other public and private providers
- Developed a long range plan report and care model to determine the cost of providing needed services in the community
- Created and launched the NC PIC (Practice Improvement Collaborative), which is comprised of academics, reserarchers,providers, consumer and family members to continually review literature and identify new and emerging best practices.

As a Council, we see improvements in the NC system of care in meeting the national outcomes measured in this report. We know that system challenges still exist. We do believe by building on strengths and encouraging next steps, we will see critical elements in a system of care framework to meet all consumer, family and youth strengths and needs.

The Council recognizes the advocacy by the Governor, the NC Department of Health and Human Services and NC Division of MH/DD/SAS on behalf of consumers, children, youth and their families evidenced in these transformation gains. North Carolina is working and moving toward a system in which consumers, families, policy makers, advocates, and qualified providers will unite in a common approach that emphasizes education/training, rehabiitation, supports and recovery.

As a Council, we see that the NC Division of MH/DD/SAS listens to and considers the input of consumers in a number of ways. The NC Mental Health Planning & Advisory Council has also been an active participant in this dialogue. The Council believes that we will continue to have more opportunities to meaningfully participate in next steps in moving the system forward We look forward to the future in working to see these changes in positive block grant outcomes across all levels in our state.

Sincerely,

Jeff McLoud, Chair

North Carolina

Appendix B (Optional)

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.

Spheres of Influence of NC Mental Health Planning and Advisory Council Membership:
A Summary of Existing Opportunities For
NC Consumer, Youth and Family Voice, Involvement and Advocacy in NC
Updated - June 2007

State Level	Community Level Activity and/or Community Stakeholders involved in State/National Work Scope	Both
NC DHHS / Division of MHDDSAS		
DMHDDSAS/Advocacy and Customer Services Section – Customer Empowerment Team & State Facility Advocates	-Regional customer empowerment liaison network -State facility client rights/human rights committees	X X
State Consumer Family Advisory Committee (State CFAC)	Local Consumer Family Advisory Family Advisory Committee(CFAC)	X
NC Council on Community MHDDSAS Programs – Board of Directors	Local Management Entity/Area Authority Advisory Boards	X
NC Commission for Division of MHDDSA Services	Establishes state and community rules governing practice.	
NC Commission for Division of Social Services	Establishes state and community rules governing practice.	
NC Council on Developmental Disabilities	Self- Advocacy and Self Determination support networks	X
Governor's Advocacy Council for Persons with Disabilities (GACPD) - Includes Protection and Advocacy for Individuals with Mental Illness (PAIMI)	Note: Currently pending move out of Department of Administration to a non-governmental oversight.	
NC Mental Health Planning & Advisory Council	Impacts & relates to LMEs, local CFACs. providers, consumers & other stakeholders	
National-State Advocacy Opportunities		
National Alliance on Mental Illness in NC (NAMI/NC)	NAMI/NC Community Affiliates (includes Family to Family; Young Families Initiative)	X
Mental Health Association in NC (MHA/NC)	MHA/NC (includes housing)	X
National Federation for Children's Mental Health - NC Chapter (NC Families United & youth*)	Regional and community networks	X
National Coalition of MH Consumer/Survivor Organizations		X
ARC of NC, Inc.	Regional and community affiliates	X
National Commission on Correctional Healthcare		
Autism Society of NC, Inc.	Community Network	X
Easter Seals/United Cerebral Palsy of NC, Inc.	Regional and community network	X
National Assoc. of Foster Parents – NC Assoc. of Foster & Adoptive Parents		X
National Assoc. of State Mental Health Program Directors (NASMHPD) – all divisions		
National Assoc.of Special Ed. Directors & Educators (NASEDE)		
IDEA Shared Agenda Practice Communities - School Based Mental Health and Behavioral Health Services	State & community plans in action	X
American Academy of Pediatrics – NC Pediatric Society	Communities of Practice (co-located services)	X
North Carolina Specific Advocacy		

State Level	Community Level	Both
NC Treatment Outcomes Program Performance Scale (NCTOPPS) & Quality Management Advisory Committee		
Practice Improvement Collaborative (PIC) on Best Practices for Review & Implementation in MHDDSA system		
MHDDSAS "Secret Shopper" Statewide Monitoring Project		X
NC Covenant for Children	Community Network & Advocacy	X
Coalition 2010 – NC Coalition for Persons Disabled with Mental Illness, Substance Abuse Federation, DD Consortium		X
NC Mental Health Consumers' Organization	Community Network & Leadership Academy	X
Governor's Youth Advocacy and Involvement Office (YAIO)	Community Network	X
North Carolina Families United	Community Network & Policy Panel	X
Powerful Youth	Community Network	X
Strong Stable Youth Speaking Out (SAYSO)	Regional and community network	X
NC Collaborative for Children, Youth & Families	Local Community Collaboratives	X
Brain Injury Association of NC (Traumatic Brain Injury	Community Network	X
Exceptional Children's Assistance Center (ECAC)	Regional and community network	X
Family Support Network of NC (FSN/CN)	Regional and community network	X
Action for Children (former NC Child Advocacy Institute)		
NC Low Income Housing Coalition		
Division of Public Health – Parent Advisory Committee		
Commission on Children with Special Health Care Needs	SCHIP in NC-Health Choice; Birth up to age 19	
Peer Support Specialist Delineation Study Committee		
Broughton Hospital Client Rights Committee		
Crisis Intervention Training for Law Enforcement Officers	Pitt, Wake, Mecklenburg, Western Highlands	X
Going Home Initiative for Aftercare Planning (Re-entry)	Pitt County	X
NC Partners in Justice – bridges co-occurring prisoner needs		X
NC Div. of Prisons (DOP) Mental Health QA Committee		
NC Div. of Prisons HS Policy Review & Revision Committee		
NC Division of Prisons Transitions Workgroup	Community planning	X
Homeless Sex Offender Taskforce	Community planning	X
Recovery, Inc	Community network	X
Homeless Coalition	Johnston, Guilford, Wake, Richmond	X
Human Services and Interfaith Councils	Johnston, Guilford, Wake, Richmond	X
Child and Family Team from a Family Perspective - Training		X
WRAP - Training		X
Local Management Entity Client Rights Committee	State & Community review & implementation	X
Public School Systems – state & local boards	School Health Advisory Councils	X
Positive Behavior Support (PBS) Advisory Committee	Local Education Agency	X
NC Council for Exceptional Children		X
NC Interagency Coordinating Council for Children B-5 Years w/Disabilities and Their Families	Regional and Local Interagency Coordinating Councils	X
SUCCESS, Inc. & Parent Voice	Guilford county, Mecklenburg county	
Coalition Against Underage Drinking	Regional, Local and Campus coalitions	X
Family Network for Substance Abuse Prevention & Treatment		X